

SEALED

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CLERK US DISTRICT COURT
NORTHERN DIST. OF TX
FILED**NOTICE: THIS DOCUMENT CONTAINS SENSITIVE DATA. See LR 79.3**

2015 JUN 19 PM 12:58

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION**DEPUTY CLERK EAN

ORIGINAL

PARTY UNDER SEAL,**Relator,****VS.****PARTIES UNDER SEAL,****Defendants**§
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§**Case No. 3-15CV-2085L****RELATOR'S ORIGINAL COMPLAINT (UNDER SEAL)**

Respectfully submitted,

WITT, MCGREGOR & BOURLAND, P.L.L.C.By: /s/ Matthew C. Witt
MATTHEW C. WITT
State Bar No. 218317808004 Woodway Drive, Suite 400
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mattwitt@wmbwaco.com**ATTORNEYS FOR RELATOR**

NOTICE: THIS DOCUMENT CONTAINS SENSITIVE DATA. *See LR 79.3*

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION**

PARTY UNDER SEAL,

Relator,

VS.

PARTIES UNDER SEAL,

Defendants

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Case No. _____

RELATOR'S ORIGINAL COMPLAINT (UNDER SEAL)

Respectfully submitted,

WITT, McGREGOR & BOURLAND, P.L.L.C.

By: /s/ Matthew C. Witt
MATTHEW C. WITT
State Bar No. 21831780

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Waco, Texas 76712
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(254) 751-9134 *fax*
mattwitt@wmbwaco.com

**ATTORNEYS FOR PLAINTIFF
THE STATE OF TEXAS
ex rel. CLINT ANDERSON**

NOTICE: THIS DOCUMENT CONTAINS SENSITIVE DATA. See LR 79.3

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION**

PARTY UNDER SEAL,

Relator,

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Case No. _____

RELATOR'S ORIGINAL COMPLAINT (UNDER SEAL)

TO THE HONORABLE JUDGE OF SAID COURT:

Relator, Clint Anderson, files this Original Petition under seal, bringing this action based on his direct, independent, and personal knowledge and also on information and belief. Relator brings this action against Defendants for violations of Section 3729, Title 31 of the United States Code, for the United States Government (the "Government") and for himself, pursuant to the authority granted by Section 3730(b), Title 31 of the United States Code, and would show unto the Honorable Court as follows:

I.

DISCOVERY CONTROL PLAN

1. This case is filed *in camera* and under seal pursuant to Section 3730(b)(2), Title 31 of the United States Code and Local Rule 79.3. Upon unsealing, discovery is intended to be conducted under Section 3731-3733, Title 31 of the United States Code.

II.

PARTIES AND SERVICE

2.1. The Plaintiff, **Clint Anderson** ("Relator") is an individual residing in Killeen, Bell County, Texas. From May 2012 to August 2012, Relator was employed as a therapist at Ellis County Community Services, Inc., in Ellis County, Texas.

2.2. The last three digits of Plaintiff's social security number are 395.

2.3. Relator is an original source of the information underlying this Petition and the Disclosure Statement served with Relator's Original Petition. Relator has also previously provided this information to the United States Government prior to filing this Petition. Relator has independent knowledge of the information on which the allegations are based. Relator brings this action on behalf of the United States Government and himself against Defendants for treble damages and civil penalties arising from the Defendants' misrepresentations and failure to disclose material evidence, false statements, and false claims in violation of the False Claims Act, Section 3729, Title 31 of the United States Code.

2.4. Defendant Alexis Norman is an individual whose principal place of business is located at 307 North Grand Avenue, Waxahachie, Texas, 75165. Service of said Defendant as described above may be effected by personal delivery at the above address or wherever she may be found.

2.5. Defendant Greater Southwest Group Corp. is a corporation with its principal office located at 625 Jealous Way, Suite 116, Cedar Hill, Texas 75104-2578. Said Defendant may be served with process by serving its registered agent, Carlette Roberts, 625 Jealous Way, Cedar Hill, Texas 75104. Service of said Defendant as described above may be effected by personal delivery.

2.6. Defendant Ellis County Community Services, Inc. is a corporation with its principal office located at 307 North Grand Avenue, Waxahachie, Texas 75165. Said Defendant may be

served with process by serving its registered agent, Alexis Norman, 307 North Grand Avenue, Waxahachie, Texas 75165. Service of said Defendant as described above may be effected by personal delivery.

III.

JURISDICTION

3.1. The Court has jurisdiction because it is a judicial district in which the defendants can be found, reside, transact business, and which the acts at issue occurred, pursuant to Section 3732(a), Title 31 of the United States Code.

IV.

FILING UNDER SEAL

4.1. In accordance with Section 3730(b)(2), Title 31 of the United States Code and Local Rule 79.3, this Original Complaint is filed *in camera* and under seal and will not be served on the Defendants until the Court so orders.

4.2. In accordance with Section 3730(b)(2), Title 31 of United States Code, a copy of this Original Complaint and written disclosure has been served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure.

V.

FACTUAL BACKGROUND

5.1. On or about July 28, 2012, Relator had a conversation with an employee of Defendant Ellis County Community Services, Inc. ("Ellis") or Defendant Greater Southwest Group Corporation ("Greater Southwest"), Rosalba Fernandez. Ms. Fernandez mentioned that as part of her duties, she entered billing information into Ellis' software system. When Relator asked

Ms. Fernandez what type of billing she was doing, Ms. Fernandez told Relator she was doing Medicaid billing.

5.2. Relator recalled a conversation between himself and Defendant Alexis Norman, owner of Ellis ("Norman"), wherein Norman informed Relator that Ellis is a grant-funded Medicaid provider, but it does not perform Medicaid billing.

5.3. When Relator further inquired into Ms. Fernandez's billing work, Ms. Fernandez stated that she billed Medicaid often, at the direction of Norman. Ms. Fernandez told Relator that Norman gave Ms. Fernandez two large notebooks filled with client names and billing information that she entered into their software system to bill Medicaid.

5.4. Ms. Fernandez told Relator that she did not know what services she was billing Medicaid for, because Norman gave her a form that had the codes she needed to enter. Ms. Fernandez further told Relator that she was the individual that entered all of the client information into the company's software system, and she got all of the client information out of the two large notebooks Ms. Fernandez received from Norman.

5.5. Ms. Fernandez agreed to provide Relator with a copy of the billing information she told him about. Ms. Fernandez provided Relator with a copy of instructions on completing the billing forms, and a copy of a Health Insurance Claim Form ("HICF") for a client, attached hereto as Exhibits "1" and "2," respectively.

5.6. On examining the forms, Relator saw that the HICF for the client on Exhibit 2 showed Medicaid was billed for 2 hours a day for 5 consecutive days for services provided at Ellis' Grand Avenue location ("Grand Avenue"). However, the client's address was in a city approximately 6.5 hours from the Grand Avenue location. Relator asked Ms. Criner, the program

manager at Grand Avenue, if she knew the client. Ms. Criner told Relator she had never met or seen the client's name listed on billing.

5.7. When Relator further investigated Exhibit 2, he discovered that his NPI (National Provider Identifier) number had been used on this client's HICF to bill Medicaid. However, Relator was not working at Grand Avenue on the dates listed on the HICF. Therefore, he contacted the only provider working at Grand Avenue on the dates listed on the HICF, Mr. Van Zandt, to determine if the client was Mr. Van Zandt's patient. Mr. Van Zandt stated that he did not know the client listed on the HICF, and he was on vacation during the dates listed on the HICF.

5.8. On July 30, 2012, Relator asked Ms. Criner for the attendance log for Grand Avenue for the dates listed on the HICF in Exhibit 2, which Ms. Criner provided for him. The client on the HICF was not listed on the Grand Avenue attendance log. Ms. Criner again told Relator she did not know the client whose name appeared on the HICF.

5.9. On or about August 3, 2012, Ms. Fernandez provided Relator with a folder containing HICF sheets for approximately 17 other clients for services allegedly provided by Ellis at the Grand Avenue location. These items are attached hereto as Exhibits 3-19. On several of the HICF sheets, Relator's NPI number was used for services that were allegedly provided prior to Relator's beginning his employment with Ellis. (Exhibits 5, 7, 8, 10, 12, 13, 17, 18, 19). Some of the HICF sheets also contain NPI numbers for other individual providers that Relator does not recognize as employees of Ellis or Greater Southwest. (Exhibits 3, 6, 9, 11). All of the clients on the HICF sheets have identical diagnostic codes and the same provider location, which is the Grand Avenue address. None of the clients are known to Relator.

5.10. Therefore, Relator believes Defendants have billed Medicaid for services they have not provided, and have billed Medicaid for services rendered to patients they have not treated.

Further, Relator believes Defendants have used his NPI number and the NPI number of other individual practitioners to bill Medicaid for services to patients that none of these practitioners have treated at the Grand Avenue location.

VI.

DEFENDANTS' UNLAWFUL ACTS UNDER THE FALSE CLAIMS ACT

- 6.1. Relator alleges and incorporates the above paragraphs as if fully set forth herein.
- 6.2. In connection with services rendered to patients covered by the Medicaid program, Defendants have conspired to and have in fact, knowingly or intentionally, caused the Medicaid program to overcharged, through the following acts:
 - a. Pursuant to Section 3729(a)(1)(A), Title 31 of the United States Code, Defendants knowingly presented, or caused to be presented, a false or fraudulent claim for payment or approval;
 - b. Pursuant to Section 3729(a)(1)(B), Title 31 of the United States Code, Defendants knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim; and
 - c. Pursuant to Section 3729(a)(1)(C), Title 31 of the United States Code, Defendants conspired to commit a violation of subparagraph (A) and (B).
- 6.3. Each of such acts and omissions by Defendants, singularly or in combination with others, constitute a False Claim.

VII.

CAUSATION

- 7.1. The United States Government made excessive Medicaid payments based upon these misrepresentations and failure to disclose material facts and was therefore damaged.
- 7.2. The Defendants have profited and the United States Government has paid excessive Medicaid reimbursements and has suffered monetary damages by the unlawful acts of Defendants.

7.3. The United States Government, unaware of Defendants' wrongdoing and unlawful acts, paid excessive Medicaid reimbursements that otherwise would not have been allowed.

7.4. Defendants' acts and omissions constitute unlawful conduct, violations of the False Claims Act, and were a legal cause, proximate cause, and/or cause-in-fact of the Government's damages.

VIII.

DAMAGES

8.1. Relator alleges and reincorporates by reference as set forth herein the allegations contained in the above paragraphs.

8.2. Pursuant to the False Claims Act, Defendants are liable for a civil penalty of not less than \$5,000 and not more than \$10,000.

8.3. Pursuant to the False Claims Act, Defendants are liable for damages to the United States Government in the amount of three (3) times the amount of damages which the Government sustains because of these acts.

8.3. This action is a claim for damages as required by Section 3729, Title 31 of the United States Code.

IX.

DEMAND FOR JURY TRIAL

9.1. Relator, on behalf of himself and the United States Government, demands a jury trial on all claims alleged herein pursuant to Rule 38 of the Federal Rules of Civil Procedure.

X.

PRAYER FOR RELIEF

WHEREFORE, Relator respectfully requests as follows:

1. That Defendants be cited to appear and answer this lawsuit;
2. That the United States Government, upon trial of this cause, be awarded the following damages:
 - a. monetary relief in the amount of any payment provided under the Medicaid program as a result of Defendants' unlawful acts;
 - b. interest on the amount of the payment at the prejudgment interest rate in effect on the date the payment was paid, for the period from the date the benefit was paid to the date that the Government recovers the amount of the payment;
 - c. a civil penalty of not less than \$5,000.00 and not more than \$10,000.00;
 - d. three (3) times the amount of the payments made by the United States Government under the Medicaid program as a result of Defendants' unlawful acts; and
 - e. post-judgment interest and reasonable attorneys' fees, costs, and expenses that the Government reasonably incurred in obtaining civil remedies or in conducting investigations in connection with this litigation; and
3. That Relator, upon trial of this cause, be awarded the following damages:
 - a. the maximum percentage of the amounts recovered by the United States Government as a result of this action in accordance with Section 3730(d), Title 31 of the United States Code; and
 - b. reasonable expenses, reasonable attorneys' fees, and costs that Relator necessarily incurred in bringing this action and advancing this case to litigation.
4. Plaintiffs further pray for such other and further relief as to which they are justly entitled.

Respectfully submitted,

WITT, McGREGOR & BOURLAND, P.L.L.C.

By: /s/ Matthew C. Witt
MATTHEW C. WITT

State Bar No. 21831780

8004 Woodway Drive, Suite 400

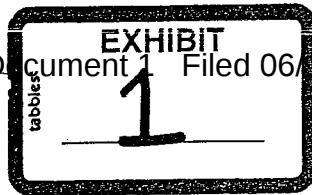
Waco, Texas 76712

(254) 751-9133

(254) 751-9134 *fax*

mattwitt@wmbwaco.com

**ATTORNEYS FOR PLAINTIFF
UNITED STATES GOVERNMENT
ex rel. CLINT ANDERSON**



CLAIMS FILING INFORMATION

Website: www.tmhp.com

Claim type form 1500

Medicaid number is also the client number

COMPANY INFORMATION

1. GREATER SOUTHWEST GROUP

307 NORTH GRAND AVENUE

WAXAHACHIE, TEXAS 75165

972-291-2929

EIN#-010866255

NPI#1619203361

DIAGNOSIS CODE-309.28

PROCEDURE CODE-90806

LOGIN-Intern75104

Password-greater3071 South3071

2. ELLIS COUNTY COMMUNITY SERVICES

625 JEALOUSE WAY

SUITE 116

CEDAR HILL, TEXAS 75104

972-768-2908

EIN#-272493382

NPI#1376864363

DIAGNOSIS CODE-309.28

PROCEDURE CODE-90806

LOGIN-Office75104

PASSWORD- ellis3071-
county 3071

87/22/2087 22:15 2147249977

EXHIBIT

2

PAGE 01/01

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE 08/05

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>				12. INSURED'S I.D. NUMBER REDACTED			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED				3. PATIENT'S BIRTH DATE REDACTED			
5. PATIENT'S ADDRESS (No. Street) REDACTED				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
7. INSURED'S ADDRESS (No. Street) REDACTED				8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED				10. IS PATIENT'S CONDITION RELATED TO: YES <input type="checkbox"/> NO <input type="checkbox"/>			
11. INSURED'S POLICY GROUP OR FECA NUMBER REDACTED				12. INSURED'S DATE OF BIRTH MM DO YY REDACTED			
13. EMPLOYER'S NAME OR SCHOOL NAME REDACTED				14. INSURANCE PLAN NAME OR PROGRAM NAME REDACTED			
15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE REDACTED			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE REDACTED				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DO YY TO MM DO YY			
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to items 1, 2, 3 or 4 to item 24E by Line) 1. 309 28				22. MEDICAID RESUBMISSION CODE REDACTED			
23. FROM AUTHORIZATION NUMBER REDACTED				24. A. DATE(S) OF SERVICE From MM DO YY To MM DO YY			
25. FEDERAL TAX I.D. NUMBER REDACTED				26. PATIENT'S ACCOUNT NO. REDACTED			
27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				28. TOTAL CHARGE \$ 960.00			
29. ACCOUNT PAID \$ 960.00				30. BALANCE DUE \$ 960.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER REDACTED				32. SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104			
33. BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104				34. BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104			

07 25 2012

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

FICA

FICA

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		1a INSURED'S ID NUMBER REDACTED	
2 PATIENT'S NAME (Last, First Name, Middle Initial) REDACTED		3 PATIENT'S BIRTH DATE REDACTED	
4 PATIENT'S ADDRESS (No. Street) REDACTED		5 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6 CITY LONGVIEW		7 STATE TX	
8 ZIP CODE 75604		9 TELEPHONE (Area Code) ()	
10 OTHER INSURED'S NAME (Last, First Name, Middle Initial) REDACTED		11 INSURED'S POLICY GROUP OR FECA NUMBER REDACTED	
12 OTHER INSURED'S DATE OF BIRTH MM DD YY		13 INSURED'S DATE OF BIRTH REDACTED	
14 EMPLOYER'S NAME OR SCHOOL NAME REDACTED		15 EMPLOYER'S NAME OR SCHOOL NAME REDACTED	
16 INSURANCE PLAN NAME OR PROGRAM NAME REDACTED		17 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

18 PATIENT OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to obtain payment of medical benefits to the undersigned or, when or supplier for services described below.)

19 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned or, when or supplier for services described below.)

SIGNATURE ON FILE

SIGNATURE ON FILE

20 DATE OF CURRENT ILLNESS (If injury, accident, or pregnancy, list date) MM DD YY		21 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		22 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
23 NAME OF REFERRING PROVIDER OR OTHER SOURCE (7a, NPI)		24 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		25 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Review Items 1, 2, 3 or 4 to Item 245 by Line) 309 28		27 MEDICAID RESUBMISSION CODE ORIGINAL REF NO		28 PRIOR AUTHORIZATION NUMBER	

A	B	C	D	E	F	G	H	I	J
DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS	CHARGES	DATE OF SERVICE	DATE OF SERVICE	DATE OF SERVICE	RENDERING PROVIDER ID #
MM DD YY	MM DD YY	MM DD YY	OPT, HCPCS, MODIFIER	ICD-9-CM		MM DD YY	MM DD YY	MM DD YY	
06 16 12	06 16 12	1	90847	1	160 00	2			1689948895
06 17 12	06 17 12	1	90847	1	160 00	2			1376864363
06 23 12	06 23 12	1	90847	1	160 00	2			1689948895
06 24 12	06 24 12	1	90847	1	160 00	2			1376864363

29 FEDERAL TAX ID NUMBER REDACTED		30 PATIENT'S ACCOUNT NO REDACTED		31 ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		32 TOTAL CHARGE \$ 640 00		33 AMOUNT PAID \$		34 BALANCE DUE \$ 640 00	
35 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (Explain Unusual Circumstances) 08 01 2012				36 SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104				37 BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104			

SIGNED _____ DATE _____ 1376864363 1376864363 216914601



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/12/2012 1:00:14 PM

Patient Information

[REDACTED]
[REDACTED]
[REDACTED] M
[REDACTED]
[REDACTED] LONGVIEW, TX 75601
[REDACTED] out-of-state
[REDACTED] INDIV OUTS

Inquiry Information

[REDACTED] 1376864363
[REDACTED] Eligibility From 3/1/2012
[REDACTED] Eligibility Through 3/9/2012
[REDACTED] Medicaid / Client No.
[REDACTED] Social Security Number
[REDACTED] Date of Birth
[REDACTED] Last Name
[REDACTED] First Name

Eligibility Segments

Effective Date	Segment	Category	Plan	Benefit Year
EFF: 2/1/2012	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID
TRM: 3/31/2012				
ADD: 12/21/2011				

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

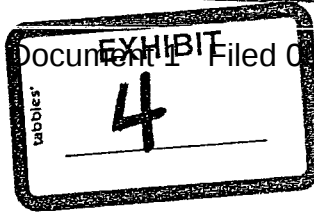
No Managed Care Segments found

Limits Segments

Effective Date	Segment	Category	Plan	Benefit Year
2/10/2012				4/6/2010

100020030201220956828368

1 Paid



Home :: TMHP.com :: My Account

Logged in as: ellis75104; Log Off

Print Options ::

Navigation

- TexMedConnect
- Acute Care
- Eligibility
- Eligibility
- Client Group List
- EV Batch History
- Claims
- Claims Entry
- Individual Template
- Draft
- Pending Batch
- Batch History
- CSI
- R&S
- Appeals
- ANSI 835
- TexMedConnect Ready

Eligibility Verification Results

New Lookup

Return with Search Criteria

ellis

Patient Information

Client No./Trainee SSN
DOB
Gender
SSN
Name
Address
County
Medicare No.
Base Plan

Inquiry Information

NPI/API
Eligibility From
Eligibility Through
Medicaid / Client No.
Social Security Number
Date of Birth
Last Name
First Name

Eligibility Segments

Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Spand-down
---------------	------------------	--------------	---------	--------------	------------

Feb
4, 5, 7, 9, 11, 12, 14, 16, 18, 19, 21, 23, 25, 26

1033273156
\$80
90806

20002003020/2048/0037113

Paid
\$0

1500

Case 3:15-cv-02085-L Document 1 Filed 06/19/15

TEXAS MEDICAL & HEALTH CARE
CLAIMS
Page 17 of 69 PageID 17

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 62/35

PCA

PCA

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		1. INSURED'S I.D. NUMBER REDACTED	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED		3. PATIENT'S BIRTH DATE REDACTED	
4. PATIENT'S ADDRESS (No. Street) REDACTED		5. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) REDACTED	
8. CITY WACO		9. STATE TX	
10. ZIP CODE 76712		11. TELEPHONE (Include Area Code) ()	
12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED		13. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. OTHER INSURED'S POLICY OR GROUP NUMBER REDACTED		15. INSURED'S POLICY GROUP OR FECA NUMBER REDACTED	
16. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		17. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
18. EMPLOYER'S NAME OR SCHOOL NAME REDACTED		19. EMPLOYER'S NAME OR SCHOOL NAME REDACTED	
20. INSURANCE PLAN NAME OR PROGRAM NAME REDACTED		21. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 2 and 3.	
22. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of reimbursement benefits either to myself or to the party who accepts assignment of benefits. SIGNED SIGNATURE ON FILE DATE		23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNATURE ON FILE	
24. DATE OF CURRENT ILLNESS (If not symptoms) OR INJURY (Accident or Pregnancy/ILMP) MM DD YY 04 03 12		25. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 04 05 12	
26. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI		27. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO 04 03 12 TO 04 05 12	
28. RESERVED FOR LOCAL USE		29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO 04 03 12 TO 04 05 12	
30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Return items 1, 2, 3 or 4 to item 24E by Line) 309 28		31. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 32. MEDICAID RESUBMISSION CODE 33. PRIOR AUTHORIZATION NUMBER	
34. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY 04 03 12 04 03 12		35. B. PLACEMENT C. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS PORTER E. CHARGES F. CHARGES G. CHARGES H. CHARGES I. CHARGES J. CHARGES K. CHARGES L. CHARGES M. CHARGES N. CHARGES O. CHARGES P. CHARGES Q. CHARGES R. CHARGES S. CHARGES T. CHARGES U. CHARGES V. CHARGES W. CHARGES X. CHARGES Y. CHARGES Z. CHARGES	
36. FEDERAL TAXID NUMBER REDACTED		37. PATIENT'S ACCOUNT NO. REDACTED	
38. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (If certified by statements on the reverse, specify test, test, and the name of the person)		39. SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	
40. BILLING PROVIDER INFO & PH# ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		41. TOTAL CHARGE \$ 960.00	
42. AMOUNT PAID \$		43. BALANCE DUE \$ 960.00	
44. SIGNED DATE 06 19 2012		45. SIGNED DATE 06 19 2012	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03.35

TEXAS MEDICARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

PICA

MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (Member ID) CHAMPVA <input type="checkbox"/> (Member ID) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID) OTHER <input type="checkbox"/> (ID)		1. INSURED'S ID NUMBER REDACTED																																																																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED		3. PATIENT'S BIRTH DATE REDACTED																																																																							
4. PATIENT'S ADDRESS (No. Street) REDACTED		5. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED																																																																							
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) REDACTED																																																																							
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>		9. CITY WACO																																																																							
10. STATE TX		11. ZIP CODE 76712																																																																							
12. TELEPHONE (Include Area Code) ()		13. TELEPHONE (Include Area Code) ()																																																																							
14. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED		15. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																							
16. OTHER INSURED'S POLICY OR GROUP NUMBER REDACTED		17. INSURED'S POLICY GROUP OR FECA NUMBER REDACTED																																																																							
18. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		19. INSURED'S DATE OF BIRTH REDACTED																																																																							
20. EMPLOYER'S NAME OR SCHOOL NAME REDACTED		21. EMPLOYER'S NAME OR SCHOOL NAME REDACTED																																																																							
22. INSURANCE PLAN NAME OR PROGRAM NAME REDACTED		23. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9-a																																																																							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 24. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.) SIGNED _____ DATE _____																																																																									
25. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____ DATE _____																																																																									
26. DATE OF CURRENT ILLNESS (From Onset of Injury, Accident, or Pregnancy) MM DD YY 04 14 12		27. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 04 15 12																																																																							
28. NAME OF REFERRING PROVIDER OR OTHER SOURCE 309 28		29. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 04 17 12 TO 04 19 12																																																																							
30. RESERVED FOR LOCAL USE		31. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 04 21 12 TO 04 22 12																																																																							
32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 309 28		33. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 34. MEDICAID RESUBMISSION CODE OR GINAL REF. NO. 35. PRIOR AUTHORIZATION NUMBER																																																																							
<table border="1"> <thead> <tr> <th>A</th> <th>B</th> <th>C</th> <th>D</th> <th>E</th> <th>F</th> <th>G</th> <th>H</th> <th>I</th> <th>J</th> </tr> <tr> <th>DATE OF SERVICE</th> <th>PLACE OF SERVICE</th> <th>PROCEDURES, SERVICES, OR SUPPLIES</th> <th>DIAGNOSIS</th> <th>S CHARGES</th> <th>RENDERING PROVIDER ID #</th> <th>DATE OF SERVICE</th> <th>PLACE OF SERVICE</th> <th>PROCEDURES, SERVICES, OR SUPPLIES</th> <th>DIAGNOSIS</th> </tr> </thead> <tbody> <tr> <td>04 14 12</td> <td>1</td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td>1871621060</td> <td>04 15 12</td> <td>1</td> <td>90847</td> </tr> <tr> <td>04 15 12</td> <td>1</td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td>1871621060</td> <td>04 17 12</td> <td>1</td> <td>90847</td> </tr> <tr> <td>04 17 12</td> <td>1</td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td>1871621060</td> <td>04 19 12</td> <td>1</td> <td>90847</td> </tr> <tr> <td>04 19 12</td> <td>1</td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td>1871621060</td> <td>04 21 12</td> <td>1</td> <td>90847</td> </tr> <tr> <td>04 21 12</td> <td>1</td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td>1871621060</td> <td>04 22 12</td> <td>1</td> <td>90847</td> </tr> </tbody> </table>				A	B	C	D	E	F	G	H	I	J	DATE OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS	S CHARGES	RENDERING PROVIDER ID #	DATE OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS	04 14 12	1	90847	1	160 00	2	1871621060	04 15 12	1	90847	04 15 12	1	90847	1	160 00	2	1871621060	04 17 12	1	90847	04 17 12	1	90847	1	160 00	2	1871621060	04 19 12	1	90847	04 19 12	1	90847	1	160 00	2	1871621060	04 21 12	1	90847	04 21 12	1	90847	1	160 00	2	1871621060	04 22 12	1	90847
A	B	C	D	E	F	G	H	I	J																																																																
DATE OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS	S CHARGES	RENDERING PROVIDER ID #	DATE OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS																																																																
04 14 12	1	90847	1	160 00	2	1871621060	04 15 12	1	90847																																																																
04 15 12	1	90847	1	160 00	2	1871621060	04 17 12	1	90847																																																																
04 17 12	1	90847	1	160 00	2	1871621060	04 19 12	1	90847																																																																
04 19 12	1	90847	1	160 00	2	1871621060	04 21 12	1	90847																																																																
04 21 12	1	90847	1	160 00	2	1871621060	04 22 12	1	90847																																																																
36. FEDERAL TAX ID NUMBER REDACTED		37. PATIENT'S ACCOUNT NO. 1376864363																																																																							
38. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include M.D. or D.O. or Credentials) 06 19 2012		39. SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104																																																																							
40. TOTAL CHARGE \$ 960 00		41. AMOUNT PAID \$ 960 00																																																																							
42. BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		43. BILLING PROVIDER INFO & PH # 1376864363																																																																							

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/95

PO BOX

AUSTIN TX 78720-0735

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER REDACTED	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED		3. PATIENT'S BIRTH DATE REDACTED SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
4. PATIENT'S ADDRESS (No. Street) REDACTED		5. INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) REDACTED	
8. CITY WACO		9. CITY WACO	
10. STATE TX		11. STATE TX	
12. ZIP CODE 76712		13. ZIP CODE 76712	
14. TELEPHONE (Include Area Code) ()		15. TELEPHONE (Include Area Code) ()	
16. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		17. IS PATIENT'S CONDITION RELATED TO	
18. OTHER INSURED'S POLICY OR GROUP NUMBER		19. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
20. OTHER INSURED'S DATE OF BIRTH MM DD YY		21. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
22. SEX <input type="checkbox"/> M <input type="checkbox"/> F		23. PLACE (S) (N)	
24. EMPLOYER'S NAME OR SCHOOL NAME		25. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. INSURANCE PLAN NAME OR PROGRAM NAME		27. 10a. RESERVED FOR LOCAL USE	
28. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 and 10		29. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below)	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

30. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment of benefits.)

SIGNED SIGNATURE ON FILE

DATE

SIGNED

SIGNATURE ON FILE

31. DATE OF CURRENT ILLNESS (First Onset) OR INJURY (Accident) OR PREGNANCY (Date)		32. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		33. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
34. NAME OF REFERRING PROVIDER OR OTHER SOURCE		35. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		36. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	
37. RESERVED FOR LOCAL USE		38. MEDICAID RESUBMISSION CODE		39. OR SIGNAL REF NO	
39. PRIOR AUTHORIZATION NUMBER		40. PRIOR AUTHORIZATION NUMBER		41. PRIOR AUTHORIZATION NUMBER	

A. DATE(S) OF SERVICE		B. PLACE		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS		F. CHARGES		G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.	
MM	DD	YY	MM	DD	YY	ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM
04	24	12	04	24	12	1	90847	1	160.00	2	1871621060
04	28	12	04	28	12	1	90847	1	160.00	2	1871621060
04	29	12	04	29	12	1	90847	1	160.00	2	1871621060

42. FEDERAL TAX ID NUMBER		43. PATIENT'S ACCOUNT NO.		44. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		45. TOTAL CHARGE \$ 480.00		46. AMOUNT PAID \$		47. BALANCE DUE \$ 480.00	
48. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address and credentials)		49. SERVICE FACILITY LOCATION INFORMATION		50. BILLING PROVIDER INFO & PH #		51. BILLING PROVIDER INFO & PH #		52. BILLING PROVIDER INFO & PH #		53. BILLING PROVIDER INFO & PH #	
ELLIS COUNTY COMMUNITY		625 JEALOUSE WAY # 116		ELLIS COUNTY COMMUNITY SERVICES, INC		625 JEALOUSE WAY # 116		ELLIS COUNTY COMMUNITY SERVICES, INC		625 JEALOUSE WAY # 116	
CEDAR HILL TX 75104		CEDAR HILL TX 75104		CEDAR HILL TX 75104		CEDAR HILL TX 75104		CEDAR HILL TX 75104		CEDAR HILL TX 75104	

06 19 2012

1376864363

1376864363 216914601



Printed on: 6/14/2012 9:05:37 PM

Patient Information

MR/AR	
DOB	
Gender	M
SSN	
Name	
Address	
City	WACO, TX 76711
County	McLennan
Medicaid No.	
Residence	INDIV OUTS

Inquiry Information

MR/AR	1376854363
Eligibility From	4/1/2012
Eligibility Through	4/30/2012
Medicaid / Client No.	
Social Security Number	
Date of Birth	
Last Name	
First Name	

Eligibility Segments

Effective Date	Program Type	Program	Benefit Plan	Spouse/Dependent Indicator
EFF : 5/1/2010 TRM : 6/30/2012 ADD : 4/9/2010	13 SSI, RECIPIENT REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Effective Date	Organization	Name	Phone
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 2/10/2012	MCNA		
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 2/10/2012	MCNA		

Limits Segments

Benefit	Effective Date	Eye Exam	Eye Glasses	General
10/11/2011		6/21/2011		5/18/2012

100020030201216743617412 / Paid

HEALTH INSURANCE CLAIM FORM

PO BOX
AUSTIN TX 78720-0735REDACTED
REDACTED

REDACTED

REDACTED
REDACTED
REDACTED

MARSHALL

TX

75670

MARSHALL

TX

75670

REDACTED

SIGNATURE ON FILE

SIGNATURE ON FILE

309 28

04	07	12	04	07	12	1	90847	1	160 00	2	1467637181
											1376864363
04	08	12	04	08	12	1	90847	1	160 00	2	1467637181
											1376864363
04	14	12	04	14	12	1	90847	1	160 00	2	1467637181
											1376864363
04	15	12	04	15	12	1	90847	1	160 00	2	1467637181
											1376864363
04	21	12	04	21	12	1	90847	1	160 00	2	1467637181
											1376864363
04	22	12	04	22	12	1	90847	1	160 00	2	1467637181
											1376864363

REDACTED

X

960 00

960 00

ELLIS COUNTY COMMUNITY
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104ELLIS COUNTY COMMUNITY SERVICES, INC
625 JEALOUSE WAY # 116
CEDAR HILL TX 75104

1376864363

1376864363 : 216914601

08 01 2012

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Ellis



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 7/22/2012 12:29:18 PM

Patient Information

Client No./Trace SSN [REDACTED]
DOB [REDACTED]
Gender [REDACTED]
SSN [REDACTED]
Name [REDACTED]
Address [REDACTED] MARSHALL, TX 75570
County [REDACTED] Harrison
Medicaid No. [REDACTED]
Base Plan [REDACTED]

Inquiry Information

NP/ADI [REDACTED] 1376354363
Eligibility From [REDACTED] 4/1/2012
Eligibility Through [REDACTED] 4/30/2012
Medicaid Client No. [REDACTED]
Social Security Number [REDACTED]
Date of Birth [REDACTED]
Last Name [REDACTED]
First Name [REDACTED]

Eligibility Segments

Segment	Dates	Medical Coverage	Program Type	Program	Health Plan	Spent some Indicate
EFF: 2/1/2012	43 RIBICOFF CHILDREN	REGULAR	R			
TRM: 7/31/2012	UNDER AGE 4 WITH INC				100 - TRADITIONAL MEDICAID	
ADD: 2/23/2012						

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

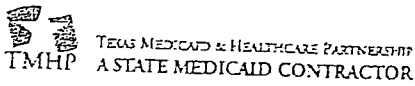
APR 1 90847
1467637181
18
1415
2122
28129

Managed Care Segments

Segment	Date	Organization	Name	Phone
EFF: 4/1/2012		DELTA DENTAL		
TRM: 7/31/2012				
ADD: 2/23/2012				

Limits Segments

Dental	Hearing Aid	Eye Exam	Eye Glasses	Medical
4/13/2011				8/30/2011



Printed on: 7/22/2012 12:29:18 PM

Patient Information

NAME	[REDACTED]
DOB	[REDACTED]
SSN	[REDACTED]
Gender	M
Address	[REDACTED]
City	[REDACTED]
State	TX
Zip	75670
County	Harrison

Inquiry Information

Ref/Ad	1376864363
Eligibility From	4/1/2012
Eligibility Through	4/30/2012
Medicaid / Client No	[REDACTED]
Social Security Number	[REDACTED]
Date of Birth	[REDACTED]
Last Name	[REDACTED]
First Name	[REDACTED]

Eligibility Segments

Effective Date	Segment Name	Category	Program	Reason for Eligibility
EFF: 2/1/2012	43 RIBICOFF CHILDREN	REGULAR	R	100 - TRADITIONAL MEDICAID
TRM: 7/31/2012	UNDER AGE 4 WITH INC			
ADD: 2/23/2012				

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Effective Date	Segment Name	Category
EFF: 4/1/2012	DELTA DENTAL	Private
TRM: 7/31/2012		
ADD: 2/23/2012		

Limits Segments

Effective Date	Segment Name	Category
4/13/2011		
		8/30/2011

100020030201220956819353

AUSTIN TX 78720-0735

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/06

7123

542

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BULKING OTHER 13 INSURED'S ID NUMBER (For Program in Item 11)

2 PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED

3 PATIENT'S BIRTH DATE REDACTED SEX M X F

4 INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED

5 PATIENT'S ADDRESS (No. Street) REDACTED

6 PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

7 INSURED'S ADDRESS (No. Street) REDACTED

8 CITY KILLEEN STATE TX

9 ZIP CODE 76549 TELEPHONE (Include Area Code) ()

10 IS PATIENT'S CONDITION RELATED TO

11 INSURED'S POLICY GROUP OR FECA NUMBER

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to the party who accepts assignment.

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14 DATE OF CURRENT ILLNESS (If first symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI 17b NPI

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19 OUTSIDE LAB? YES NO 5 CHARGES

20 MEDICAID RESUBMISSION CODE ORIGINAL REF NO.

21 PRIOR AUTHORIZATION NUMBER

22 DATE(S) OF SERVICE From To PLACE OF SERVICE ENG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS POINTER F 5 CHARGES G DAYS OF CARE H DAYS OF CARE I CUAL J RENDERING PROVIDER ID 1

23 FEDERAL TAX ID NUMBER SSN EIN 24 PATIENT'S ACCOUNT NO 25 ACCEPT ASSIGNMENT? YES NO 26 TOTAL CHARGE 27 AMOUNT PAID 28 BALANCE DUE

29 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 30 SERVICE FACILITY LOCATION INFORMATION 31 BILLING PROVIDER INFO & PH 1

32 ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104 33 ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104

06 01 2012 1376864363 1376864363 216914601

Ellis



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/13/2012 9:46:52 AM

Patient Information

Client No./Alt. Client SSN	[REDACTED]
DOB	[REDACTED]
Gender	M
SSN	[REDACTED]
Name	[REDACTED]
Address	[REDACTED]
County	Bell
Medicaid No.	[REDACTED]
Resident	INDIV OUTS
City	KILLEEN, TX 75549

Inquiry Information

Net/Alt	1619203351
Eligibility From	3/1/2012
Eligibility Through	3/9/2012
Medicaid/Client No.	[REDACTED]
Social Security Number	[REDACTED]
Date of Birth	[REDACTED]
Last Name	[REDACTED]
First Name	[REDACTED]

Eligibility Segments

Effective Date	Reason for Eligibility	Program Type	Program	Benefit Plan	Spend-down Indicator
EFF: 7/1/2010	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	
TRM: 3/31/2012					
ADD: 5/20/2010					

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Effective Date	Organization	Name	Phone
EFF: 3/1/2012	MCNA		
TRM: 3/31/2012			
ADD: 2/10/2012			
EFF: 3/1/2012	MCNA		
TRM: 3/31/2012			
ADD: 2/10/2012			

Limits Segments

Effective Date	Program	Program	Program	Program
7/9/2009				8/17/2010

#100020030201215339812483 / Paid

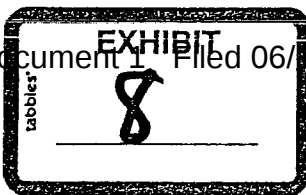
1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (2.0)

FICA

FICA


 CLAIMS
 PO BOX
 AUSTIN TX 78720-0735

CARRIER

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		12. INSURED'S ID NUMBER (For Program, a form 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. INSURED'S NAME (Last Name, First Name, Middle Initial)	
4. PATIENT'S ADDRESS (No. Street)		5. INSURED'S ADDRESS (No. Street)	
6. PATIENT'S STATUS		7. INSURED'S STATUS	
8. PATIENT'S DATE OF BIRTH		9. INSURED'S DATE OF BIRTH	
10. PATIENT'S RELATIONSHIP TO INSURED		11. INSURED'S POLICY GROUP OR FECA NUMBER	
13. PATIENT'S EMPLOYMENT (Current or Previous)		14. INSURED'S EMPLOYMENT (Current or Previous)	
15. PATIENT'S AUTO ACCIDENT?		16. INSURED'S AUTO ACCIDENT?	
17. PATIENT'S OTHER ACCIDENT?		18. INSURED'S OTHER ACCIDENT?	
19. PATIENT'S RESERVATION FOR LOCAL USE		20. INSURED'S RESERVATION FOR LOCAL USE	
21. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
22. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I do not request payment of government benefits other to myself or to the party who accepts assignment below.)		23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
24. SIGNATURE ON FILE		25. SIGNATURE ON FILE	
26. DATE OF CURRENT ILLNESS (If symptoms or injury (accident) or pregnancy (LMP))		27. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE	
28. NAME OF REFERRING PROVIDER OR OTHER SOURCE		29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
30. RESERVED FOR LOCAL USE		31. OUTSIDE LAB? \$ CHARGES	
32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		33. MEDICAID RESUBMISSION CODE	
34. DATE(S) OF SERVICE		35. PRIOR AUTHORIZATION NUMBER	
36. PROCEDURE(S), SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		37. RENDERING PROVIDER ID	
38. FEDERAL TAX ID NUMBER		39. PATIENT'S ACCOUNT NO	
40. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		41. SERVICE FACILITY LOCATION INFORMATION	
42. SIGNATURE OF PHYSICIAN OR SUPPLIER		43. BILLING PROVIDER INFO & PH	
44. SIGNATURE OF PHYSICIAN OR SUPPLIER		45. BILLING PROVIDER INFO & PH	
46. SIGNATURE OF PHYSICIAN OR SUPPLIER		47. BILLING PROVIDER INFO & PH	
48. SIGNATURE OF PHYSICIAN OR SUPPLIER		49. BILLING PROVIDER INFO & PH	
49. SIGNATURE OF PHYSICIAN OR SUPPLIER		50. BILLING PROVIDER INFO & PH	
51. SIGNATURE OF PHYSICIAN OR SUPPLIER		52. BILLING PROVIDER INFO & PH	
53. SIGNATURE OF PHYSICIAN OR SUPPLIER		54. BILLING PROVIDER INFO & PH	
55. SIGNATURE OF PHYSICIAN OR SUPPLIER		56. BILLING PROVIDER INFO & PH	
57. SIGNATURE OF PHYSICIAN OR SUPPLIER		58. BILLING PROVIDER INFO & PH	
59. SIGNATURE OF PHYSICIAN OR SUPPLIER		60. BILLING PROVIDER INFO & PH	
61. SIGNATURE OF PHYSICIAN OR SUPPLIER		62. BILLING PROVIDER INFO & PH	
63. SIGNATURE OF PHYSICIAN OR SUPPLIER		64. BILLING PROVIDER INFO & PH	
65. SIGNATURE OF PHYSICIAN OR SUPPLIER		66. BILLING PROVIDER INFO & PH	
67. SIGNATURE OF PHYSICIAN OR SUPPLIER		68. BILLING PROVIDER INFO & PH	
69. SIGNATURE OF PHYSICIAN OR SUPPLIER		70. BILLING PROVIDER INFO & PH	
71. SIGNATURE OF PHYSICIAN OR SUPPLIER		72. BILLING PROVIDER INFO & PH	
73. SIGNATURE OF PHYSICIAN OR SUPPLIER		74. BILLING PROVIDER INFO & PH	
75. SIGNATURE OF PHYSICIAN OR SUPPLIER		76. BILLING PROVIDER INFO & PH	
77. SIGNATURE OF PHYSICIAN OR SUPPLIER		78. BILLING PROVIDER INFO & PH	
79. SIGNATURE OF PHYSICIAN OR SUPPLIER		80. BILLING PROVIDER INFO & PH	
81. SIGNATURE OF PHYSICIAN OR SUPPLIER		82. BILLING PROVIDER INFO & PH	
83. SIGNATURE OF PHYSICIAN OR SUPPLIER		84. BILLING PROVIDER INFO & PH	
85. SIGNATURE OF PHYSICIAN OR SUPPLIER		86. BILLING PROVIDER INFO & PH	
87. SIGNATURE OF PHYSICIAN OR SUPPLIER		88. BILLING PROVIDER INFO & PH	
89. SIGNATURE OF PHYSICIAN OR SUPPLIER		90. BILLING PROVIDER INFO & PH	
91. SIGNATURE OF PHYSICIAN OR SUPPLIER		92. BILLING PROVIDER INFO & PH	
93. SIGNATURE OF PHYSICIAN OR SUPPLIER		94. BILLING PROVIDER INFO & PH	
95. SIGNATURE OF PHYSICIAN OR SUPPLIER		96. BILLING PROVIDER INFO & PH	
97. SIGNATURE OF PHYSICIAN OR SUPPLIER		98. BILLING PROVIDER INFO & PH	
99. SIGNATURE OF PHYSICIAN OR SUPPLIER		100. BILLING PROVIDER INFO & PH	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

E/11/15



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/13/2012 9:48:05 AM

Patient Information

SSN	[REDACTED]
DOB	[REDACTED]
Gender	M
SSN	[REDACTED]
Name	[REDACTED]
Address	[REDACTED] TEMPLE, TX 7650 [REDACTED]
County	Bell
Medicaid No.	[REDACTED]
Base Plan	[REDACTED]

Inquiry Information

Not/My	1619203361
Eligibility From	3/1/2012
Eligibility Through	3/9/2012
Medicaid / Other No.	[REDACTED]
Social Security Number	[REDACTED]
Date of Birth	[REDACTED]
Last Name	[REDACTED]
First Name	[REDACTED]

Eligibility Segments

Segment Dates	Medical Assistance	Program Type	Program	Benefit Plan	Special Determination
EFF : 12/1/2011 TRM : 3/31/2012 ADD : 1/4/2012	44 MEDICAID EXPANSION FOR CHILDREN (FEDER	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found.

Lock-In Segments

No Lock-In Segments found.

TPR Segments

No TPR Segments found.

TPL Segments

No TPL Segments found.

Managed Care Segments

Segment Dates	Organization	Name	Phone
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA		
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/10/2012	MCNA		

Limits Segments

Date	Reason for	Program	Eye Glasses	Medical
2/28/2012				9/15/2011

#100020030201215339812476 / paid

1500

Case 3:15-cv-02085-L Document 1 Filed 06/19/15

TEXAS MEDICAID & HEALTH CARE
CLAIMS
Page 29 of 69 PageID 29

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/05

PICA

PO BOX
AUSTIN TX 78720-0735

<input type="checkbox"/> MEDICARE (Medicare #)		<input checked="" type="checkbox"/> MEDICAID (Medicaid #)		<input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN)		<input type="checkbox"/> CHAMPVA (Member ID)		<input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID)		<input type="checkbox"/> FECA BLK LRG (SSN)		<input type="checkbox"/> OTHER (ID)		1a. INSURED'S ID NUMBER (For Program in Item 1)																																																																																											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted										3. PATIENT'S BIRTH DATE Redacted		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURER'S NAME (Last Name, First Name, Middle Initial) Redacted																																																																																											
5. PATIENT'S ADDRESS (No. Street) Redacted										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) Redacted																																																																																													
CITY BOERNE				STATE TX				8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY BOERNE				STATE TX																																																																																									
ZIP CODE 78006				TELEPHONE (Include Area Code) ()				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																													
11. INSURED'S POLICY GROUP OR FECA NUMBER				12. INSURED'S DATE OF BIRTH MM DD YY Redacted				SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>				13. EMPLOYER'S NAME OR SCHOOL NAME																																																																																													
14. INSURANCE PLAN NAME OR PROGRAM NAME				15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d				16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																																	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																									
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.																																																																																																									
SIGNED SIGNATURE ON FILE DATE																																																																																																									
18. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP)				19. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY				20. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																	
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE				22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				23. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO				24. MEDICAID RESUBMISSION CODE OR GINAL REF NO																																																																																													
25. RESERVED FOR LOCAL USE				26. PRIOR AUTHORIZATION NUMBER				27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Recode Items 1, 2, 3 or 4 to Item 24E by Line)				309 28																																																																																													
<table border="1"> <thead> <tr> <th>DATE(S) OF SERVICE</th> <th>PLACED</th> <th>C</th> <th>D</th> <th>E</th> <th>F</th> <th>G</th> <th>H</th> <th>I</th> <th>J</th> </tr> <tr> <th>From To</th> <th>DATE</th> <th>ENG</th> <th>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th>DIAGNOSIS</th> <th>S CHARGES</th> <th>DATE</th> <th>DATE</th> <th>DATE</th> <th>RENDERING PROVIDER ID #</th> </tr> </thead> <tbody> <tr> <td>06 02 12 06 02 12</td> <td>1</td> <td></td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td></td> <td></td> <td>1689948895</td> </tr> <tr> <td>06 03 12 06 03 12</td> <td>1</td> <td></td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td></td> <td></td> <td>1376864363</td> </tr> <tr> <td>06 09 12 06 09 12</td> <td>1</td> <td></td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td></td> <td></td> <td>1689948895</td> </tr> <tr> <td>06 10 12 06 10 12</td> <td>1</td> <td></td> <td>90847</td> <td>1</td> <td>160 00</td> <td>2</td> <td></td> <td></td> <td>1376864363</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>																DATE(S) OF SERVICE	PLACED	C	D	E	F	G	H	I	J	From To	DATE	ENG	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS	S CHARGES	DATE	DATE	DATE	RENDERING PROVIDER ID #	06 02 12 06 02 12	1		90847	1	160 00	2			1689948895	06 03 12 06 03 12	1		90847	1	160 00	2			1376864363	06 09 12 06 09 12	1		90847	1	160 00	2			1689948895	06 10 12 06 10 12	1		90847	1	160 00	2			1376864363																														
DATE(S) OF SERVICE	PLACED	C	D	E	F	G	H	I	J																																																																																																
From To	DATE	ENG	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS	S CHARGES	DATE	DATE	DATE	RENDERING PROVIDER ID #																																																																																																
06 02 12 06 02 12	1		90847	1	160 00	2			1689948895																																																																																																
06 03 12 06 03 12	1		90847	1	160 00	2			1376864363																																																																																																
06 09 12 06 09 12	1		90847	1	160 00	2			1689948895																																																																																																
06 10 12 06 10 12	1		90847	1	160 00	2			1376864363																																																																																																
28. FEDERAL TAX ID NUMBER Redacted				29. PATIENT'S ACCOUNT NO				30. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				31. TOTAL CHARGE \$ 640 00				32. AMOUNT PAID \$				33. BALANCE DUE \$ 640 00																																																																																					
34. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS I certify that the statements on the reverse apply to the services rendered.																																																																																																									
35. SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104																																																																																																									
36. BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104																																																																																																									
SIGNED DATE 08 01 2012				37. 1376864363				38. 1376864363				39. 216914601																																																																																													

E1115



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 7/22/2012 12:52:17 PM

Patient Information

First Name	[REDACTED]
Last Name	[REDACTED]
Gender	F
Address	[REDACTED]
City	BOERNE, TX 78008
County	Kendall
State	TX
Zip	78008

Inquiry Information

NPV/APL	1376854353
Effective Date	6/1/2012
Eligibility Through	5/30/2012
Medicaid/Parent No	[REDACTED]
Social Security Number	[REDACTED]
Date of Birth	[REDACTED]
Last Name	[REDACTED]
First Name	[REDACTED]

8

Eligibility Segments

Effective Date	Termination Date	Program Type	Program	Benefit Plan	Notes
EFF: 9/1/2011	21 ADOPTION SUBSIDY	REGULAR	R	100 - TRADITIONAL MEDICAID	
TRM: 7/31/2012	PROGRAM				
ADD: 8/3/2011					

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Effective Date	Termination Date	Managed Care Organization	Member ID
EFF: 3/1/2012	DENTAQUEST	NICOLE C LOUGHLIN	(830) 249-9838
TRM: 7/31/2012			
ADD: 2/12/2012			

Limits Segments

Effective Date	Termination Date	Limit Type	Limit Value
9/1/2011		Medical	4/22/2009

100020030201220956822399 / paid

1500

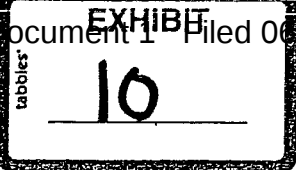
Case 3:15-cv-02085-L

Document 1 Filed 06/19/15

Page 3 of 3 MEDICAID

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/05

TEXAS MEDICAID RAISED RATE CARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		13. INSURED'S ID. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last, First, Middle Initial)		4. INSURED'S NAME (Last, First, Middle Initial)	
3. PATIENT'S BIRTH DATE		5. INSURED'S ADDRESS (No. Street)	
6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S POLICY GROUP OR FECA NUMBER	
8. PATIENT STATUS		9. INSURED'S DATE OF BIRTH	
10. IS PATIENT'S CONDITION RELATED TO		11. EMPLOYER'S NAME OR SCHOOL NAME	
12. IS THERE ANOTHER HEALTH BENEFIT PLAN?		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
14. DATE OF CURRENT ILLNESS (First, Second, or Third)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS	
16. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
18. RESERVED FOR LOCAL USE		19. OUTSIDE LAB? \$ CHARGES	
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		21. MEDICAID RESUBMISSION CODE	
22. MEDICAID RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	
C. D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS	
F. \$ CHARGES		G. PAYMENT	
H. ICD-9 CODE		J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX ID NUMBER		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE	
29. AMOUNT PAID		30. BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER		32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH #		34. SIGNATURE OF PHYSICIAN OR SUPPLIER	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CLAIMS
PO BOX
AUSTIN TX 78720-0735

FICA

FICA

1 MEDICARE <input type="checkbox"/> (Medicare ID) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid ID) <input type="checkbox"/> TRICARE <input type="checkbox"/> (Tricare ID) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Champva ID) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (Group Health Plan ID) <input type="checkbox"/> FECA <input type="checkbox"/> (FECA ID) <input type="checkbox"/> OTHER <input type="checkbox"/> (Other ID)		1a INSURED'S ID NUMBER (For Program 1 item 1) Redacted	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) REDACTED		3 PATIENT'S BIRTH DATE <input type="checkbox"/> SEX <input checked="" type="checkbox"/>	
5 PATIENT'S ADDRESS (No. Street) REDACTED		7 INSURED'S ADDRESS (No. Street) REDACTED	
CITY LONGVIEW		CITY LONGVIEW	
STATE TX		STATE TX	
ZIP CODE 75604		ZIP CODE 75604	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) REDACTED		11 INSURED'S POLICY GROUP OR FECA NUMBER REDACTED	
10 IS PATIENT'S CONDITION RELATED TO YES <input type="checkbox"/> NO <input type="checkbox"/>		12 INSURED'S DATE OF BIRTH <input type="checkbox"/> SEX <input checked="" type="checkbox"/>	
13 EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>		14 EMPLOYER'S NAME OR SCHOOL NAME REDACTED	
15 AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		16 INSURANCE PLAN NAME OR PROGRAM NAME REDACTED	
17 OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		18 IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 a-d	
19 RESERVED FOR LOCAL USE		20 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below) REDACTED	
21 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of my claim benefits either to myself or to the party who accepts assignment below) REDACTED		22 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below) REDACTED	
23 SIGNATURE ON FILE SIGNED _____ DATE _____		24 SIGNATURE ON FILE SIGNED _____ DATE _____	
25 DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (UMP) MM DD YY		26 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
27 NAME OF REFERRING PROVIDER OR OTHER SOURCE REDACTED		28 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
29 RESERVED FOR LOCAL USE		30 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
31 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Follow Items 1, 2, 3 or 4 to Item 34e by Line) 309 28		32 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> CHARGES	
33 MEDICAID RESUBMISSION CODE 309 28		34 ORIGINAL REF NO	
35 PRIOR AUTHORIZATION NUMBER		36 PRIOR AUTHORIZATION NUMBER	
37 DATE(S) OF SERVICE From To MM DD YY MM DD YY		38 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
39 DIAGNOSIS PORTER		40 CHARGES	
41 DAYS ON LIST		42 RENDERING PROVIDER ID #	
43 DATE(S) OF SERVICE From To MM DD YY MM DD YY		44 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
45 DIAGNOSIS PORTER		46 CHARGES	
47 DAYS ON LIST		48 RENDERING PROVIDER ID #	
49 DATE(S) OF SERVICE From To MM DD YY MM DD YY		50 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
51 DIAGNOSIS PORTER		52 CHARGES	
53 DAYS ON LIST		54 RENDERING PROVIDER ID #	
55 DATE(S) OF SERVICE From To MM DD YY MM DD YY		56 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
57 DIAGNOSIS PORTER		58 CHARGES	
59 DAYS ON LIST		60 RENDERING PROVIDER ID #	
61 DATE(S) OF SERVICE From To MM DD YY MM DD YY		62 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
63 DIAGNOSIS PORTER		64 CHARGES	
65 DAYS ON LIST		66 RENDERING PROVIDER ID #	
67 DATE(S) OF SERVICE From To MM DD YY MM DD YY		68 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
69 DIAGNOSIS PORTER		70 CHARGES	
71 DAYS ON LIST		72 RENDERING PROVIDER ID #	
73 DATE(S) OF SERVICE From To MM DD YY MM DD YY		74 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
75 DIAGNOSIS PORTER		76 CHARGES	
77 DAYS ON LIST		78 RENDERING PROVIDER ID #	
79 DATE(S) OF SERVICE From To MM DD YY MM DD YY		80 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
81 DIAGNOSIS PORTER		82 CHARGES	
83 DAYS ON LIST		84 RENDERING PROVIDER ID #	
85 DATE(S) OF SERVICE From To MM DD YY MM DD YY		86 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
87 DIAGNOSIS PORTER		88 CHARGES	
89 DAYS ON LIST		90 RENDERING PROVIDER ID #	
91 DATE(S) OF SERVICE From To MM DD YY MM DD YY		92 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
93 DIAGNOSIS PORTER		94 CHARGES	
95 DAYS ON LIST		96 RENDERING PROVIDER ID #	
97 DATE(S) OF SERVICE From To MM DD YY MM DD YY		98 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
99 DIAGNOSIS PORTER		100 CHARGES	
101 DAYS ON LIST		102 RENDERING PROVIDER ID #	
103 DATE(S) OF SERVICE From To MM DD YY MM DD YY		104 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
105 DIAGNOSIS PORTER		106 CHARGES	
107 DAYS ON LIST		108 RENDERING PROVIDER ID #	
109 DATE(S) OF SERVICE From To MM DD YY MM DD YY		110 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
111 DIAGNOSIS PORTER		112 CHARGES	
113 DAYS ON LIST		114 RENDERING PROVIDER ID #	
115 DATE(S) OF SERVICE From To MM DD YY MM DD YY		116 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
117 DIAGNOSIS PORTER		118 CHARGES	
119 DAYS ON LIST		120 RENDERING PROVIDER ID #	
121 DATE(S) OF SERVICE From To MM DD YY MM DD YY		122 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
123 DIAGNOSIS PORTER		124 CHARGES	
125 DAYS ON LIST		126 RENDERING PROVIDER ID #	
127 DATE(S) OF SERVICE From To MM DD YY MM DD YY		128 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
129 DIAGNOSIS PORTER		130 CHARGES	
131 DAYS ON LIST		132 RENDERING PROVIDER ID #	
133 DATE(S) OF SERVICE From To MM DD YY MM DD YY		134 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
135 DIAGNOSIS PORTER		136 CHARGES	
137 DAYS ON LIST		138 RENDERING PROVIDER ID #	
139 DATE(S) OF SERVICE From To MM DD YY MM DD YY		140 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
141 DIAGNOSIS PORTER		142 CHARGES	
143 DAYS ON LIST		144 RENDERING PROVIDER ID #	
145 DATE(S) OF SERVICE From To MM DD YY MM DD YY		146 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
147 DIAGNOSIS PORTER		148 CHARGES	
149 DAYS ON LIST		150 RENDERING PROVIDER ID #	
151 DATE(S) OF SERVICE From To MM DD YY MM DD YY		152 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
153 DIAGNOSIS PORTER		154 CHARGES	
155 DAYS ON LIST		156 RENDERING PROVIDER ID #	
157 DATE(S) OF SERVICE From To MM DD YY MM DD YY		158 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
159 DIAGNOSIS PORTER		160 CHARGES	
161 DAYS ON LIST		162 RENDERING PROVIDER ID #	
163 DATE(S) OF SERVICE From To MM DD YY MM DD YY		164 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
165 DIAGNOSIS PORTER		166 CHARGES	
167 DAYS ON LIST		168 RENDERING PROVIDER ID #	
169 DATE(S) OF SERVICE From To MM DD YY MM DD YY		170 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
171 DIAGNOSIS PORTER		172 CHARGES	
173 DAYS ON LIST		174 RENDERING PROVIDER ID #	
175 DATE(S) OF SERVICE From To MM DD YY MM DD YY		176 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
177 DIAGNOSIS PORTER		178 CHARGES	
179 DAYS ON LIST		180 RENDERING PROVIDER ID #	
181 DATE(S) OF SERVICE From To MM DD YY MM DD YY		182 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
183 DIAGNOSIS PORTER		184 CHARGES	
185 DAYS ON LIST		186 RENDERING PROVIDER ID #	
187 DATE(S) OF SERVICE From To MM DD YY MM DD YY		188 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
189 DIAGNOSIS PORTER		190 CHARGES	
191 DAYS ON LIST		192 RENDERING PROVIDER ID #	
193 DATE(S) OF SERVICE From To MM DD YY MM DD YY		194 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
195 DIAGNOSIS PORTER		196 CHARGES	
197 DAYS ON LIST		198 RENDERING PROVIDER ID #	
199 DATE(S) OF SERVICE From To MM DD YY MM DD YY		200 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
201 DIAGNOSIS PORTER		202 CHARGES	
203 DAYS ON LIST		204 RENDERING PROVIDER ID #	
205 DATE(S) OF SERVICE From To MM DD YY MM DD YY		206 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
207 DIAGNOSIS PORTER		208 CHARGES	
209 DAYS ON LIST		210 RENDERING PROVIDER ID #	
211 DATE(S) OF SERVICE From To MM DD YY MM DD YY		212 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
213 DIAGNOSIS PORTER		214 CHARGES	
215 DAYS ON LIST		216 RENDERING PROVIDER ID #	
217 DATE(S) OF SERVICE From To MM DD YY MM DD YY		218 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
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225 DIAGNOSIS PORTER		226 CHARGES	
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229 DATE(S) OF SERVICE From To MM DD YY MM DD YY		230 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
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237 DIAGNOSIS PORTER		238 CHARGES	
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241 DATE(S) OF SERVICE From To MM DD YY MM DD YY		242 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
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247 DATE(S) OF SERVICE From To MM DD YY MM DD YY		248 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
249 DIAGNOSIS PORTER		250 CHARGES	
251 DAYS ON LIST		252 RENDERING PROVIDER ID #	
253 DATE(S) OF SERVICE From To MM DD YY MM DD YY		254 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
255 DIAGNOSIS PORTER		256 CHARGES	
257 DAYS ON LIST		258 RENDERING PROVIDER ID #	
259 DATE(S) OF SERVICE From To MM DD YY MM DD YY		260 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
261 DIAGNOSIS PORTER		262 CHARGES	
263 DAYS ON LIST		264 RENDERING PROVIDER ID #	
265 DATE(S) OF SERVICE From To MM DD YY MM DD YY		266 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
267 DIAGNOSIS PORTER		268 CHARGES	
269 DAYS ON LIST		270 RENDERING PROVIDER ID #	
271 DATE(S) OF SERVICE From To MM DD YY MM DD YY		272 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
273 DIAGNOSIS PORTER		274 CHARGES	
275 DAYS ON LIST		276 RENDERING PROVIDER ID #	
277 DATE(S) OF SERVICE From To MM DD YY MM DD YY		278 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
279 DIAGNOSIS PORTER		280 CHARGES	
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297 DIAGNOSIS PORTER		298 CHARGES	
299 DAYS ON LIST		300 RENDERING PROVIDER ID #	
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303 DIAGNOSIS PORTER		304 CHARGES	
305 DAYS ON LIST		306 RENDERING PROVIDER ID #	
307 DATE(S) OF SERVICE From To MM DD YY MM DD YY		308 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
309 DIAGNOSIS PORTER		310 CHARGES	
311 DAYS ON LIST		312 RENDERING PROVIDER ID #	
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321 DIAGNOSIS PORTER		322 CHARGES	
323 DAYS ON LIST		324 RENDERING PROVIDER ID #	
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327 DIAGNOSIS PORTER		328 CHARGES	
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331 DATE(S) OF SERVICE From To MM DD YY MM DD YY		332 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
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345 DIAGNOSIS PORTER		346 CHARGES	
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349 DATE(S) OF SERVICE From To MM DD YY MM DD YY		350 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
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353 DAYS ON LIST		354 RENDERING PROVIDER ID #	
355 DATE(S) OF SERVICE From To MM DD YY MM DD YY		356 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	
357 DIAGNOSIS PORTER		358 CHARGES	
359 DAYS ON LIST		360 RENDERING PROVIDER ID #	
361 DATE(S) OF SERVICE From To MM DD YY MM DD			



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Logged in as: ellis75104 Log Off

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Navigation

TexMedConnect

- Acute Care
- Eligibility
- Eligibility
- Client Group List
- EV Batch History
- Claims
- Claims Entry
- Individual Template
- Draft
- Pending Batch
- Batch History
- CSI
- R&S
- Appeals
- ANSI 835

TexMedConnect Ready

Eligibility Verification Results

[New Lookup](#)

[Return with Search Criteria](#)

Patient Information

Client No./Trainee SSN: [REDACTED]
 DOB: [REDACTED]
 Gender: F
 SSN: [REDACTED]
 Name: [REDACTED]
 Address: [REDACTED] LONGVIEW, TX 75604
 County: [REDACTED]
 Medicare No.: [REDACTED]
 Base Plan: [REDACTED]

Inquiry Information

NPI/API: 1375654363
 Eligibility From: 2/1/2012
 Eligibility Through: 2/17/2012
 Medicaid / Client No.: [REDACTED]
 Social Security Number: [REDACTED]
 Date of Birth: [REDACTED]
 Last Name: [REDACTED]
 First Name: [REDACTED]

Eligibility Segments

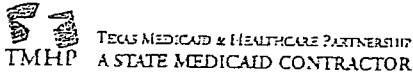
Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Stand-down
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Creator

Feb
 4, 5, 7, 9, 11, 12, 14, 18, 19, 25, 26, 27, 28, 29, 30

1902036890
 \$80
 90806

2002003020 120480 9996674



Printed on: 3/13/2012 12:10:16 PM

Patient Information

MR/MS/NAME/DOB	
DOB	
Gender	F
SSN	
Name	
Address	
City	LONGVIEW, TX 75004
County	Gregg
Medicaid No.	
Base Plan	

Inquiry Information

MR/MS	1519203351
Eligibility From	3/1/2012
Eligibility Through	3/9/2012
Medicaid Client No.	
Social Security Number	
Date of Birth	
Last Name	
First Name	

Eligibility Segments

Effective Date	Policy Number	Applicant Type	Program	Segment Name	Non-Resident Indicator
EFF: 12/1/2011	44 MEDICAID EXPANSION	REGULAR	R	100 - TRADITIONAL MEDICAID	
TRM: 3/31/2012	FOR CHILDREN (FEDER				
ADD: 11/9/2011					

12hrs

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Segment Name	Organization	Time	Phone
EFF: 3/1/2012	MCNA		
TRM: 3/31/2012			
ADD: 2/10/2012			
EFF: 3/1/2012	MCNA		
TRM: 3/31/2012			
ADD: 2/10/2012			

Limits Segments

Effective Date	Effective Date	Effective Date	Effective Date
2/9/2009	2/9/2009	11/5/2002	

#100020030201215339811731 / paid

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08-05

FICA

TEXAS MEDICARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE	
Redacted		Redacted	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S RELATIONSHIP TO INSURED	
Redacted		Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)	
Redacted		Redacted	
CITY	STATE	CITY	STATE
MARSHALL	TX	MARSHALL	TX
ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
75672	()	75672	()
8. PATIENT STATUS		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		a. OTHER INSURED'S POLICY OR GROUP NUMBER	
Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>		b. OTHER INSURED'S DATE OF BIRTH	
10. IS PATIENT'S CONDITION RELATED TO:		c. EMPLOYER'S NAME OR SCHOOL NAME	
a. EMPLOYMENT? (Current or Previous)		d. INSURANCE PLAN NAME OR PROGRAM NAME	
YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. AUTO ACCIDENT?		a. INSURED'S DATE OF BIRTH	
YES <input type="checkbox"/> NO <input type="checkbox"/>		Redacted	
c. OTHER ACCIDENT?		b. EMPLOYER'S NAME OR SCHOOL NAME	
YES <input type="checkbox"/> NO <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME	
10a. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 2 and	
12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED SIGNATURE ON FILE		SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE	
MM DD YY		MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
17a. NPI		FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
		FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		20. OUTSIDE LAB? S CHARGES	
309 28		YES <input type="checkbox"/> NO <input type="checkbox"/>	
2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE		23. PRIOR AUTHORIZATION NUMBER	
From To			
MM DD YY MM DD YY			
B. PLACE OF SERVICE		F. S CHARGES	
C. EMIG		G. DAYS OR WEEKS	
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		H. ICD-9-CM	
E. DIAGNOSIS POINTER		I. J. REMITTING PROVIDER ID	
09 03 10 09 03 10 1 90806 1 113 10 2 NPI 205568302 1427381987			
09 04 10 09 04 10 1 90806 1 113 10 2 NPI 205568302 1427381987			
09 05 10 09 05 10 1 90806 1 113 10 2 NPI 205568302 1427381987			
09 07 10 09 07 10 1 90806 1 113 10 2 NPI 205568302 1427381987			
09 09 10 09 09 10 1 90806 1 113 10 2 NPI 205568302 1427381987			
09 11 10 09 11 10 1 90806 1 113 10 2 NPI 205568302 1427381987			
25. FEDERAL TAX ID NUMBER SSN EIN		27. ACCEPT ASSIGNMENT?	
Redacted <input type="checkbox"/> <input checked="" type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
26. PATIENT'S ACCOUNT NO.		28. TOTAL CHARGE	
		\$ 678 60	
29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.		29. AMOUNT PAID	
30. SERVICE FACILITY LOCATION INFORMATION		30. BALANCE DUE	
GREATER SOUTHWEST GROUP 625 JEALOUSE WAY #113 CEDAR HILL TX 75104		\$ 678 60	
31. BILLING PROVIDER INFO & PH			
(972) 2912929			
GREATER SOUTHWEST GROUP 625 JEALOUSE WAY #113 CEDAR HILL TX 75104			
32. SIGNATURE OF PHYSICIAN OR SUPPLIER			
10 20 2010			
DATE			
1619203361			
1619203361		207547501	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE 03-05

PICA

 CLAIMS
 PO BOX
 AUSTIN TX 78720-0735

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		12. INSURED'S I.D. NUMBER Redacted																																																																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		3. PATIENT'S BIRTH DATE Redacted																																																																																					
5. PATIENT'S ADDRESS (No., Street) Redacted		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted																																																																																					
CITY MARSHALL		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																					
STATE TX		7. INSURED'S ADDRESS (No., Street) Redacted																																																																																					
ZIP CODE 75672		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																																																																																					
TELEPHONE (Include Area Code) ()		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted																																																																																					
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																																																					
1. OTHER INSURED'S POLICY OR GROUP NUMBER Redacted		b. EMPLOYER'S NAME OR SCHOOL NAME Redacted																																																																																					
2. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME Redacted																																																																																					
3. EMPLOYER'S NAME OR SCHOOL NAME Redacted		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 and 10.																																																																																					
4. INSURANCE PLAN NAME OR PROGRAM NAME Redacted		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. SIGNED _____ DATE _____																																																																																							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO S CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 309 28 22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. S CHARGES G. DAYS CH LEFTS H. EPSDT Family Plan I. ID J. RENDERING PROVIDER ID <table border="1"> <tr> <td>09</td><td>12</td><td>10</td><td>09</td><td>12</td><td>10</td><td>1</td><td>90806</td><td>1</td><td>113</td><td>10</td><td>2</td><td>NPI</td><td>205568302</td> </tr> <tr> <td>09</td><td>14</td><td>10</td><td>09</td><td>14</td><td>10</td><td>1</td><td>90806</td><td>1</td><td>113</td><td>10</td><td>2</td><td>NPI</td><td>1427381987</td> </tr> <tr> <td>09</td><td>16</td><td>10</td><td>09</td><td>16</td><td>10</td><td>1</td><td>90806</td><td>1</td><td>113</td><td>10</td><td>2</td><td>NPI</td><td>205568302</td> </tr> <tr> <td>09</td><td>18</td><td>10</td><td>09</td><td>18</td><td>10</td><td>1</td><td>90806</td><td>1</td><td>113</td><td>10</td><td>2</td><td>NPI</td><td>1427381987</td> </tr> <tr> <td>09</td><td>19</td><td>10</td><td>09</td><td>19</td><td>10</td><td>1</td><td>90806</td><td>1</td><td>113</td><td>10</td><td>2</td><td>NPI</td><td>205568302</td> </tr> <tr> <td>09</td><td>21</td><td>10</td><td>09</td><td>21</td><td>10</td><td>1</td><td>90806</td><td>1</td><td>113</td><td>10</td><td>2</td><td>NPI</td><td>1427381987</td> </tr> </table>				09	12	10	09	12	10	1	90806	1	113	10	2	NPI	205568302	09	14	10	09	14	10	1	90806	1	113	10	2	NPI	1427381987	09	16	10	09	16	10	1	90806	1	113	10	2	NPI	205568302	09	18	10	09	18	10	1	90806	1	113	10	2	NPI	1427381987	09	19	10	09	19	10	1	90806	1	113	10	2	NPI	205568302	09	21	10	09	21	10	1	90806	1	113	10	2	NPI	1427381987
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25. FEDERAL TAX I.D. NUMBER Redacted																																																																																							
26. PATIENT'S ACCOUNT NO. 1619203361																																																																																							
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																																																																																							
28. TOTAL CHARGE \$ 678 60																																																																																							
29. AMOUNT PAID \$ 678 60																																																																																							
30. BALANCE DUE \$ 678 60																																																																																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION GREATER SOUTHWEST GROUP 625 JEALOUSE WAY #113 CEDAR HILL TX 75104																																																																																							
33. BILLING PROVIDER INFO & PH # (972) 2912929 GREATER SOUTHWEST GROUP 625 JEALOUSE WAY #113 CEDAR HILL TX 75104																																																																																							

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/95

FICA

FICA

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER		1a. INSURED'S I.D. NUMBER Redacted	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		3. PATIENT'S BIRTH DATE Redacted	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted		5. PATIENT'S ADDRESS (No. Street) Redacted	
6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) Redacted	
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. INSURED'S CITY MARSHALL	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER Redacted	
12. PATIENT'S DATE OF BIRTH MM DD YY Redacted		13. INSURED'S DATE OF BIRTH MM DD YY Redacted	
14. PATIENT'S SEX M <input type="checkbox"/> F <input type="checkbox"/>		15. INSURED'S SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
16. EMPLOYER'S NAME OR SCHOOL NAME Redacted		17. EMPLOYER'S NAME OR SCHOOL NAME Redacted	
18. INSURANCE PLAN NAME OR PROGRAM NAME Redacted		19. INSURANCE PLAN NAME OR PROGRAM NAME Redacted	
20. RESERVED FOR LOCAL USE		21. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
22. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED: _____ SIGNATURE ON FILE		23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: _____ SIGNATURE ON FILE	
24. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		25. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY	
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30. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line) 309 28		31. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	
32. MEDICAID RESUBMISSION CODE Redacted		33. ORIGINAL REF. NO. Redacted	
34. PRIOR AUTHORIZATION NUMBER Redacted		35. MEDICAID RESUBMISSION CODE Redacted	
36. DATE(S) OF SERVICE From MM DD YY To MM DD YY		37. PLACE OF SERVICE ENG	
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9/1/2010 10:00 AM

9/1/2010 10:00 AM

9/1/2010 10:00 AM

Eligibility Verification Results

View Results

Return when Search Complete

Claims

Claims History

Individual Claims

Group

Waiting Period

Waiting Period

Waiting Period

Waiting Period

Waiting Period

Waiting Period

Waiting Period

Waiting Period

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Waiting Period

Patient Information

Client No./Trainer SSN

DOB

Gender

Sex

Name

Address

County

Medicaid No.

Case Plan

Inquiry Information

NP/APP

1619203361

Eligibility From

10/1/2010

Eligibility Through

10/9/2010

Medicaid / Client No.

Social Security Number

Date of Birth

Last Name

First Name

Eligibility Segments

Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Spends-down Indicator
EFF: 9/1/2010 TRM: 10/31/2010 ADD: 10/4/2010	44 MEDICAID EXPANSION FOR CHILDREN (FEDER	REGULAR	R	100 - TRADITIONAL MEDICAID	

TexMedConnect Ready

00020030201028864694395

Traditional

Sept
4/5
11/12
18/19
25/20
31
9/14
16/21
23/28
30
Robinson
142-2381987

1500

Case 3:15-cv-02085-L Document 1 Filed 06/19/15

TEXAS MEDICAID & HEALTH CARE CLAIMS

Page 39 of 69 Page ID 39

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/03

PO BOX

AUSTIN TX 78720-0735

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input checked="" type="checkbox"/> (Medicaid #)		TRICARE <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (Member ID)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA <input type="checkbox"/> (SSN)		OTHER <input type="checkbox"/> (ID)		13. INSURED'S ID NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE		SEX		14. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)										6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No. Street)			
CITY										STATE		CITY		STATE	
SWEETWATER										TX		SWEETWATER		TX	
ZIP CODE										TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)	
79556										()		79556		()	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO		11. INSURED'S POLICY GROUP OR FECA NUMBER			
9. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous)		12. INSURED'S DATE OF BIRTH		SEX	
										<input type="checkbox"/> YES <input type="checkbox"/> NO		Redacted		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	
10. OTHER INSURED'S DATE OF BIRTH										b. AUTO ACCIDENT?		c. EMPLOYER'S NAME OR SCHOOL NAME			
MM DD YY										<input type="checkbox"/> YES <input type="checkbox"/> NO		d. INSURANCE PLAN NAME OR PROGRAM NAME			
M <input type="checkbox"/> F <input type="checkbox"/>										c. OTHER ACCIDENT?					
11. EMPLOYER'S NAME OR SCHOOL NAME										<input type="checkbox"/> YES <input type="checkbox"/> NO					
12. INSURANCE PLAN NAME OR PROGRAM NAME										101. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, return to and complete item 9 and 10	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment on my behalf.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE

SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
MM DD YY	MM DD YY	MM DD YY	MM DD YY	FROM MM DD YY	TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
				FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? S CHARGES			
		<input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Rebate Items 1, 2, 3 or 4 to item 24E by Line)		3		22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO.	
309 28					
23. PRIOR AUTHORIZATION NUMBER		4			
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From MM DD YY To MM DD YY	YY	EMG	CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
03 03 12 03 03 12	1		90847		1
03 04 25 03 04 12	1		90847		1
03 06 12 03 06 12	1		90847		1
03 08 12 03 08 12	1		90847		1
03 10 12 03 10 12	1		90847		1
03 11 12 03 11 12	1		90847		1
F. S CHARGES		G. S CH CH UNITS		H. I D QUAL	
160 00	2				
I. J. RENDERING PROVIDER ID #		K. L. NPI			
1871621060					
1376864363					
1871621060					
1376864363					
1871621060					
1376864363					
1871621060					
1376864363					
1871621060					
1376864363					

25. FEDERAL TAX ID NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
Redacted	<input type="checkbox"/> <input checked="" type="checkbox"/>		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	\$ 960 00	\$	\$ 960 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Include all the statements on the reverse apply to this line and are made a part thereof)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
	ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104

06 05 2012

SIGNED DATE 1376864363 1376864363 216914601

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/05

220

PO BOX
AUSTIN TX 78720-0735

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLX/LUG <input type="checkbox"/> OTHER <input type="checkbox"/>		13. INSURED'S ID NUMBER Redacted	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted	
3. PATIENT'S ADDRESS (No. Street) Redacted		7. INSURED'S ADDRESS (No. Street) Redacted	
CITY SWEETWATER		CITY SWEETWATER	
STATE TX		STATE TX	
ZIP CODE 79556		ZIP CODE 79556	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO	
6. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
7. OTHER INSURED'S DATE OF BIRTH MM DD YY		12. INSURED'S DATE OF BIRTH MM DD YY	
SEX M <input type="checkbox"/> F <input type="checkbox"/>		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
8. EMPLOYER'S NAME OR SCHOOL NAME		9. EMPLOYER'S NAME OR SCHOOL NAME	
10. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURANCE PLAN NAME OR PROGRAM NAME	
12. RESERVED FOR LOCAL USE		13. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 5 and 6	
14. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits which to myself or to the party and accept assignment of claim.		15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefit to the undersigned physician or supplier for services described below.	
SIGNATURE ON FILE SIGNED _____ DATE _____		SIGNATURE ON FILE SIGNED _____ DATE _____	
16. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		17. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
20. RESERVED FOR LOCAL USE		21. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO S CHARGES	
22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		23. MEDICAID RESUBMISSION CODE ORIGINAL REF NO	
309 28		24. PRIOR AUTHORIZATION NUMBER	
24. A. DATES OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE	
C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS I MODIFIER		E. DIAGNOSIS POINTER	
F. S CHARGES		G. DAYS CH LATE	
H. ICD-9-CM		J. RENDERING PROVIDER ID #	
03 13 12 03 13 12 1 90847 1 160 00 2 NPI		1871621060 1376864363	
03 15 12 03 15 12 1 90847 1 160 00 2 NPI		1871621060 1376864363	
03 17 12 03 17 12 1 90847 1 160 00 2 NPI		1871621060 1376864363	
03 18 12 03 18 12 1 90847 1 160 00 2 NPI		1871621060 1376864363	
03 20 12 03 20 12 1 90847 1 160 00 2 NPI		1871621060 1376864363	
03 22 12 03 22 12 1 90847 1 160 00 2 NPI		1871621060 1376864363	
25. FEDERAL TAX ID NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO	
Redacted <input type="checkbox"/> <input checked="" type="checkbox"/>		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If applying for the statements on the reverse apply both 28 and 29 to each patient.)		29. SERVICE FACILITY LOCATION INFORMATION	
06 05 2012		ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	
30. BILLING PROVIDER INFO & PH #		31. BILLING PROVIDER INFO & PH #	
1376864363 216914601		1376864363 216914601	
32. TOTAL CHARGE \$ 960 00		33. AMOUNT PAID \$	
34. BALANCE DUE \$ 960 00			

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/05

PO BOX

AUSTIN TX 78720-0735

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		2. MEDICAID <input checked="" type="checkbox"/> (Medicaid #)		3. TRICARE CHAMPUS (Sponsor's SSN)		4. CHAMPVA (Member ID)		5. GROUP HEALTH PLAN (SSN or ID)		6. FECA BLK (LANG SSN)		7. OTHER (ID)		12. INSURED'S ID NUMBER (For Programs 2 thru 7) Redacted																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted								3. PATIENT'S BIRTH DATE MM DD YY Redacted		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted																																							
5. PATIENT'S ADDRESS (No. Street) Redacted								6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) Redacted																																									
CITY SWEETWATER				STATE TX				8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY SWEETWATER				STATE TX																																			
ZIP CODE 79556				TELEPHONE (Include Area Code) ()				Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE 79556				TELEPHONE (Include Area Code) ()																																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
1. OTHER INSURED'S POLICY OR GROUP NUMBER								a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO				3. INSURED'S DATE OF BIRTH MM DD YY Redacted				SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY								c. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				5. EMPLOYER'S NAME OR SCHOOL NAME				6. EMPLOYER'S NAME OR SCHOOL NAME																																			
7. EMPLOYER'S NAME OR SCHOOL NAME								d. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				e. INSURANCE PLAN NAME OR PROGRAM NAME				f. INSURANCE PLAN NAME OR PROGRAM NAME																																			
9. INSURANCE PLAN NAME OR PROGRAM NAME								10a. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d																																							
<p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.</p> <p>SIGNATURE ON FILE</p> <p>SIGNED _____ DATE _____</p>																<p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>SIGNATURE ON FILE</p> <p>SIGNED _____</p>																																			
14. DATE OF CURRENT ILLNESS (If not symptoms or injury (accident) or pregnancy (IMP))				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																																			
MM DD YY				MM DD YY				FROM MM DD YY TO MM DD YY				FROM MM DD YY TO MM DD YY				19. RESERVED FOR LOCAL USE																																			
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO																21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				22. MEDICAID RESUBMISSION CODE				ORIGINAL REF NO.																											
309 28																				23. PRIOR AUTHORIZATION NUMBER																															
24. A. DATE(S) OF SERVICE																B. PLACE OF SERVICE				C. ENG				D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER				F. CHARGES				G. PAY OR DATE				H. PAY PER				I. QUAL				J. RENDERING PROVIDER ID, #			
MM DD YY				MM DD YY				YY				YY				CPT/HCPCS				MODIFIER																															
03 27 12				03 27 12				1								90847				1				160 00				2												1871621060											
																																												NPI: 1376864363							
03 29 12				03 29 12				1								90847				1				160 00				2												1871621060											
																																												NPI: 1376864363							
03 31 12				03 31 12				1								90847				1				160 00				2												1871621060											
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																																												NPI:							
25. FEDERAL TAX ID NUMBER																26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT?				28. TOTAL CHARGE				29. AMOUNT PAID				30. BALANCE DUE																			
Redacted																				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				\$ 480 00				\$				\$ 480 00																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS																32. SERVICE FACILITY LOCATION INFORMATION																33. BILLING PROVIDER INFO & PH #																			
I certify that the statements on the reverse apply to this claim and are made a part thereof.																ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104																ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104																			
06 05 2012																a. 1376864363																b. 1376864363 c. 216914601																			
SIGNED _____																DATE _____																																			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/13/2012 12:15:49 PM

Patient Information

Client No. / Source SSN [REDACTED]
DOB [REDACTED]
Gender M
SSN [REDACTED]
Name [REDACTED]
Address [REDACTED] SWEETWATER, TX 79556
County Nolan
Medicaid No. [REDACTED]
Base Plan INDIV OUTS

Inquiry Information

NPI / API 1619203361
Eligibility From 3/1/2012
Eligibility through 3/9/2012
Medicaid / Client No. [REDACTED]
Social Security Number [REDACTED]
Date of Birth [REDACTED]
Last Name [REDACTED]
First Name [REDACTED]

Eligibility Segments

Segment Dates	Method of Coverage	Program Type	Program	Benefit Plan	Specialty Indicator
EFF : 9/1/2011 TRM : 3/31/2012 ADD : 7/26/2011	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Segment Dates	Organization	Name	Phone
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/15/2012	DENTAQUEST	[REDACTED]	[REDACTED]
EFF : 3/1/2012 TRM : 3/31/2012 ADD : 2/15/2012	DENTAQUEST	[REDACTED]	[REDACTED]

Limits Segments

Medicaid	Medicaid No.	By Plan	By Client	Medical
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

100020030201215340627062 / paid

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03.05

FICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

13

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BULKING (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>		12. INSURED'S ID. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		3. PATIENT'S BIRTH DATE Redacted	
4. PATIENT'S ADDRESS (No., Street) Redacted		5. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted	
6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) Redacted	
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>		9. INSURED'S POLICY GROUP OR FECA NUMBER	
10. IS PATIENT'S CONDITION RELATED TO a. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO b. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S DATE OF BIRTH Redacted	
13. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		14. INSURED'S DATE OF BIRTH Redacted	
15. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		16. EMPLOYER'S NAME OR SCHOOL NAME	
17. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		18. INSURANCE PLAN NAME OR PROGRAM NAME	
19. INSURANCE PLAN NAME OR PROGRAM NAME		20. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 and 10	
21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. SIGNED _____ DATE _____		22. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____	
23. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		24. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
25. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI		26. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY	
27. RESERVED FOR LOCAL USE		28. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
29. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24e by Line) 309 28		30. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
31. MEDICAID RESUBMISSION CODE		32. ORIGINAL REF NO	
33. PRIOR AUTHORIZATION NUMBER		34. CHARGES	
35. DATE(S) OF SERVICE From To MM DD YY MM DD YY		36. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
37. DIAGNOSIS PORTER		38. CHARGES	
39. DATE(S) OF SERVICE From To MM DD YY MM DD YY		40. CHARGES	
41. DATE(S) OF SERVICE From To MM DD YY MM DD YY		42. CHARGES	
43. DATE(S) OF SERVICE From To MM DD YY MM DD YY		44. CHARGES	
45. DATE(S) OF SERVICE From To MM DD YY MM DD YY		46. CHARGES	
47. DATE(S) OF SERVICE From To MM DD YY MM DD YY		48. CHARGES	
49. DATE(S) OF SERVICE From To MM DD YY MM DD YY		50. CHARGES	
51. DATE(S) OF SERVICE From To MM DD YY MM DD YY		52. CHARGES	
53. DATE(S) OF SERVICE From To MM DD YY MM DD YY		54. CHARGES	
55. DATE(S) OF SERVICE From To MM DD YY MM DD YY		56. CHARGES	
57. DATE(S) OF SERVICE From To MM DD YY MM DD YY		58. CHARGES	
59. DATE(S) OF SERVICE From To MM DD YY MM DD YY		60. CHARGES	
61. DATE(S) OF SERVICE From To MM DD YY MM DD YY		62. CHARGES	
63. DATE(S) OF SERVICE From To MM DD YY MM DD YY		64. CHARGES	
65. DATE(S) OF SERVICE From To MM DD YY MM DD YY		66. CHARGES	
67. DATE(S) OF SERVICE From To MM DD YY MM DD YY		68. CHARGES	
69. DATE(S) OF SERVICE From To MM DD YY MM DD YY		70. CHARGES	
71. DATE(S) OF SERVICE From To MM DD YY MM DD YY		72. CHARGES	
73. DATE(S) OF SERVICE From To MM DD YY MM DD YY		74. CHARGES	
75. DATE(S) OF SERVICE From To MM DD YY MM DD YY		76. CHARGES	
77. DATE(S) OF SERVICE From To MM DD YY MM DD YY		78. CHARGES	
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439. DATE(S) OF SERVICE From To MM DD YY MM DD YY		440. CHARGES	
441. DATE(S) OF SERVICE From To MM DD YY MM DD YY		442. CHARGES	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/05

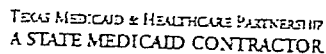
PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		12. INSURED'S ID NUMBER (For Programs in Item 1)	
2. PATIENT'S NAME (Last, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE	
Redacted		Redacted	
4. PATIENT'S ADDRESS (No. Street)		5. INSURED'S NAME (Last, First Name, Middle Initial)	
Redacted		Redacted	
6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No. Street)	
Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		Redacted	
CITY		CITY	
TEMPLE		TEMPLE	
STATE		STATE	
TX		TX	
ZIP CODE		ZIP CODE	
76501-		76501-	
TELEPHONE (Include Area Code)		TELEPHONE (Include Area Code)	
()		()	
8. PATIENT STATUS		9. INSURED'S DATE OF BIRTH	
Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		Redacted	
Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>		SEX	
10. IS PATIENT'S CONDITION RELATED TO		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. EMPLOYMENT? (Current or Previous)		12. INSURED'S DATE OF BIRTH	
YES <input type="checkbox"/> NO <input type="checkbox"/>		Redacted	
b. AUTO ACCIDENT?		13. EMPLOYER'S NAME OR SCHOOL NAME	
YES <input type="checkbox"/> NO <input type="checkbox"/>		14. INSURANCE PLAN NAME OR PROGRAM NAME	
c. OTHER ACCIDENT?		15. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 and 10	
16. RESERVATION FOR LOCAL USE		17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below)	
18. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		19. SIGNATURE ON FILE	
19. SIGNATURE ON FILE		20. DATE OF CURRENT ILLNESS (If for symptoms) OR INJURY (Accident) OR PREGNANCY/IMP.	
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE		22. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
23. RESERVED FOR LOCAL USE		24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)		26. OUTSIDE LAB? \$ CHARGES	
309 28		YES <input type="checkbox"/> NO <input type="checkbox"/>	
27. MEDICAID RESUBMISSION CODE		28. PRIOR AUTHORIZATION NUMBER	
29. ORIGINAL REF. NO.		30. DATE(S) OF SERVICE	
31. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances)		32. PLACE OF SERVICE	
33. MODIFIER		34. DIAGNOSIS POINTER	
35. \$ CHARGES		36. DAYS OF USE	
37. \$ CHARGES		38. RENDERING PROVIDER ID #	
39. FEDERAL TAX ID NUMBER		40. PATIENT'S ACCOUNT NO	
41. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials)		42. ACCEPT ASSIGNMENT?	
43. SERVICE FACILITY LOCATION INFORMATION		44. TOTAL CHARGE	
45. BILLING PROVIDER INFO & P#		46. AMOUNT PAID	
47. BALANCE DUE		48. SIGNATURE OF PHYSICIAN OR SUPPLIER	
49. DATE		50. DATE	
51. NUCC Instruction Manual available at www.nucc.org		52. APPROVED AND 03/05/05 FORM 014	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Patient Information

Full Name	Nov. 1941
DOB	
SSN	
Address	
City	
State	
Zip	
Phone	
Religion	
Marital Status	
Children	
Education	
Employment	
Interests	
References	
Comments	

RFID APP	1619203351
Eligibility From	3/17/2012
Eligibility Through	3/9/2012
Medicaid / Unifund No.	
Social Security Number	
Date of Birth	
Last Name	
First Name	

Eligibility Segments

EFF: 10/1/2011	01 TANF, CASH GRANT	REGULAR	R	100 - TRADITIONAL MEDICAID
TRM: 3/31/2012				
ADD: 8/23/2011				

12hrs

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

EFF : 3/1/2012 MCNA
TRM : 3/31/2012
ADD : 2/10/2012
EFF : 3/1/2012 MCNA
TRM : 3/31/2012
ADD : 2/10/2012

Limits Segments

3/7/2011 9/14/2011
#100020030201215339802781 / Paid

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

EXHIBIT

14

EXTRA MEDICAL & HEALTHCARE

CLAIMS

PO BOX

AUSTIN TX 78720-0735

CARRIER

MED CARE <input type="checkbox"/> MED DRO <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		1. INSURED'S ID NUMBER	
2. PATIENT'S NAME (Last, First, Middle Initial)		3. PATIENT'S BIRTH DATE	
4. PATIENT'S ADDRESS (No. Street)		5. PATIENT'S RELATIONSHIP TO INSURED	
6. PATIENT'S STATUS		7. INSURED'S ADDRESS (No. Street)	
8. PATIENT'S EMPLOYMENT		9. INSURED'S POLICY GROUP OR FECA NUMBER	
10. IS PATIENT'S CONDITION RELATED TO		11. INSURED'S DATE OF BIRTH	
12. IS THERE ANOTHER HEALTH BENEFIT PLAN?		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
14. DATE OF CURRENT ILLNESS		15. DATES PATIENT UNABLE TO WORK	
16. HOSPITALIZATION DATES		17. OUTSIDE LAB CHARGES	
18. MEDICAID RESUBMISSION CODE		19. PRIOR AUTHORIZATION NUMBER	
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		21. SIGNATURE OF PHYSICIAN OR SUPPLIER	
22. FEDERAL TAX ID NUMBER		23. PATIENT'S ACCOUNT NO	
24. SERVICE FACILITY LOCATION INFORMATION		25. ACCEPT ASSIGNMENT?	
26. BILLING PROVIDER INFO & PH		27. TOTAL CHARGE	
28. AMOUNT PAID		29. BALANCE DUE	

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

EXHIBIT 14

EXTRA MEDICAL & HEALTHCARE CLAIMS PO BOX AUSTIN TX 78720-0735

CARRIER

1. INSURED'S ID NUMBER

2. PATIENT'S NAME (Last, First, Middle Initial)

3. PATIENT'S BIRTH DATE

4. PATIENT'S ADDRESS (No. Street)

5. PATIENT'S RELATIONSHIP TO INSURED

6. PATIENT'S STATUS

7. INSURED'S ADDRESS (No. Street)

8. PATIENT'S EMPLOYMENT

9. INSURED'S POLICY GROUP OR FECA NUMBER

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S DATE OF BIRTH

12. IS THERE ANOTHER HEALTH BENEFIT PLAN?

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS

15. DATES PATIENT UNABLE TO WORK

16. HOSPITALIZATION DATES

17. OUTSIDE LAB CHARGES

18. MEDICAID RESUBMISSION CODE

19. PRIOR AUTHORIZATION NUMBER

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

21. SIGNATURE OF PHYSICIAN OR SUPPLIER

22. FEDERAL TAX ID NUMBER

23. PATIENT'S ACCOUNT NO

24. SERVICE FACILITY LOCATION INFORMATION

25. ACCEPT ASSIGNMENT?

26. BILLING PROVIDER INFO & PH

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104

ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104

1376864363 216914601

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE 02-03

FICA

CLAIMS

PO BOX

AUSTIN TX 78720-0735

FICA

<input type="checkbox"/> MED CARE <input checked="" type="checkbox"/> MEDICARE <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLK/LUNG <input type="checkbox"/> OTHER		1. INSURED'S ID NUMBER Redacted	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		3. PATIENT'S BIRTH DATE Redacted	
4. PATIENT'S ADDRESS (No. Street) Redacted		5. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) Redacted	
8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>		9. CITY BROWNWOOD	
10. STATE TX		11. CITY BROWNWOOD	
12. ZIP CODE 76801		13. STATE TX	
14. TELEPHONE (Include Area Code) ()		15. ZIP CODE 76801	
16. TELEPHONE (Include Area Code) ()		17. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
18. OTHER INSURED'S POLICY OR GROUP NUMBER		19. IS PATIENT'S CONDITION RELATED TO	
20. OTHER INSURED'S DATE OF BIRTH MM DD YY		21. IS EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. SEX M <input type="checkbox"/> F <input type="checkbox"/>		23. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
24. EMPLOYER'S NAME OR SCHOOL NAME		25. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
26. INSURANCE PLAN NAME OR PROGRAM NAME		27. 10d RESERVED FOR LOCAL USE	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I do not intend payment of payment benefits either to myself or to the entity who accepts assignment.

SIGNED SIGNATURE ON FILE

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned or provider or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (If not symptoms) OR INJURY (Accident) OR PREGNANCY (MP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	
20. RESERVED FOR LOCAL USE		21. MEDICAL RESUBMISSION CODE ORIGINAL REF NO		22. PRIOR AUTHORIZATION NUMBER	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Provide items 1, 2, 3 or 4 to item 24E by Line)		24. 309 28		25. CHARGES	

A. DATE(S) OF SERVICE		B. PLACE		C. PROCEDURE, SERVICE, OR SUPPLIES		D. CHARGES		E. DIAGNOSIS		F. CHARGES		G. PAYOR		H. PROVIDER		
From	To	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY
05	12	12	05	12	12	1	90847	1	160	00	2	NPI	187	162	1060	
05	13	12	05	13	12	1	90847	1	160	00	2	NPI	187	162	1060	
05	15	12	05	15	12	1	90847	1	160	00	2	NPI	187	162	1060	
05	17	12	05	17	12	1	90847	1	160	00	2	NPI	187	162	1060	
05	19	12	05	19	12	1	90847	1	160	00	2	NPI	187	162	1060	
05	20	12	05	20	12	1	90847	1	160	00	2	NPI	187	162	1060	

26. FEDERAL TAX ID NUMBER

SSN EIN

27. PATIENT'S ACCOUNT NO

28. ACCEPT ASSIGNMENT?

29. TOTAL CHARGE

30. AMOUNT PAID

31. BALANCE DUE

32. SIGNATURE OF PHYSICIAN OR SUPPLIER

33. SERVICE FACILITY LOCATION INFORMATION

34. BILLING PROVIDER INFO & PH

ELLIS COUNTY COMMUNITY SERVICES, INC

625 JEALOUSE WAY # 116

CEDAR HILL TX 75104

06 25 2012

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NUCC Instruction Manual available at www.nucc.org

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/05

PICA

CLAIMS

PO BOX

AUSTIN TX 78720-0735

CARRIER

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		14 INSURED'S ID NUMBER Redacted	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		3 PATIENT'S BIRTH DATE Redacted	
5 PATIENT'S ADDRESS (No. Street) Redacted		6 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
4 CITY BROWNWOOD		7 INSURED'S ADDRESS (No. Street) Redacted	
8 STATE TX		9 PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
10 ZIP CODE 76801		11 INSURED'S CITY BROWNWOOD	
12 TELEPHONE (Include Area Code) ()		13 INSURED'S STATE TX	
14 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted		15 INSURED'S POLICY GROUP OR FECA NUMBER Redacted	
16 OTHER INSURED'S POLICY OR GROUP NUMBER Redacted		17 INSURED'S DATE OF BIRTH Redacted	
18 OTHER INSURED'S DATE OF BIRTH MM DD YY		19 EMPLOYER'S NAME OR SCHOOL NAME Redacted	
20 EMPLOYER'S NAME OR SCHOOL NAME Redacted		21 INSURANCE PLAN NAME OR PROGRAM NAME Redacted	
22 INSURANCE PLAN NAME OR PROGRAM NAME Redacted		23 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 24 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary for payment of medical benefits to the undersigned or person or persons or persons designated below)			
SIGNED Redacted		SIGNED Redacted	
25 DATE OF CURRENT ILLNESS (If not dependent on injury (Accident) OR PREGNANCY (LMP)) MM DD YY		26 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
27 NAME OF REFERRING PROVIDER OR OTHER SOURCE Redacted		28 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
29 RESERVED FOR LOCAL USE		30 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
31 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Report items 1, 2, 3 or 4 to Item 24E by Line) 309 28		32 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
33 MEDICAID RESUBMISSION CODE Redacted		34 ORIGINAL REF NO. Redacted	
35 PRIOR AUTHORIZATION NUMBER Redacted		36 RENDERING PROVIDER ID Redacted	
37 A DATE(S) OF SERVICE From MM DD YY To MM DD YY		38 B C D E F G H I J PLACE OF SERVICE ENC OPT. HCPCS MODIFIER DIAGNOSIS POINTS CHARGES CPT. CHG. UNIT CHG. UNIT CHG. UNIT CHG. UNIT CHG. UNIT	
05 22 12 05 22 12 1 90847		1 160 00 2 1871621060	
05 26 12 05 26 12 1 90847		1 160 00 2 1871621060	
05 27 12 05 27 12 1 90847		1 160 00 2 1871621060	
25 FEDERAL TAX ID NUMBER Redacted		26 PATIENT'S ACCOUNT NO Redacted	
27 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS Redacted		28 ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
29 SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		30 TOTAL CHARGE \$ 480 00	
31 BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		32 AMOUNT PAID \$ 480 00	
33 BALANCE DUE \$ 480 00		34 BILLING PROVIDER INFO & PH # 1376864363 216914601	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

06 25 2012

DATE



Printed on: 6/17/2012 4:23:36 PM

Patient Information

Client No. / Client SSN	
DOB	
Gender	M
SSN	
Address	
County	Brown
Medicaid No.	
Base Plan	

Inquiry Information

NPI/APP	1619203351
Eligibility From	5/1/2012
Eligibility Through	5/31/2012
Medicaid / Client No.	
Social Security Number	
Date of Birth	
Last Name	
First Name	

Eligibility Segments

Segment ID	Medical Condition	Program Type	Program	Benefit Plan	Special Program Indicator
EFF: 12/1/2011 TRM: 6/30/2012 ADD: 12/7/2011	21 ADOPTION SUBSIDY PROGRAM	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

Segment ID	Name	Address	Phone	Additional Information
EFF: 1/25/2012 TRM: 12/31/3999				Insurance Company: Insured's ID No. / SSN: Relation: Employer: Group: Coverage Code:

TPL Segments

No TPL Segments found

Managed Care Segments

Segment ID	Organization	Name	Phone
EFF: 3/1/2012 TRM: 6/30/2012 ADD: 2/10/2012	MCNA		
EFF: 3/1/2012 TRM: 6/30/2012 ADD: 2/10/2012	MCNA		

Limits Segments

Segment ID	Category	Value	Effective Date	Expiration Date
11/17/2009				11/5/2008

100020030201217345930258

EXHIBIT

Case 3:15-cv-02085-L Document 1 Filed 06/19/15

TEXAS MEDICAID & CHIP CLAIMS
Page 50 of 69 PageID 50

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/95

PICA

PICA

1 MEDICAID <input type="checkbox"/> MED CHIP <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		1a INSURED'S ID NUMBER (For Program or Item #)	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		3 PATIENT'S BIRTH DATE	
5 PATIENT'S ADDRESS (No. Street)		6 PATIENT'S RELATIONSHIP TO INSURED	
7 PATIENT'S CITY		8 PATIENT'S STATUS	
9 PATIENT'S STATE		10 IS PATIENT'S CONDITION RELATED TO:	
11 INSURED'S NAME (Last Name, First Name, Middle Initial)		12 INSURED'S DATE OF BIRTH	
13 INSURED'S ADDRESS (No. Street)		14 INSURED'S POLICY GROUP OR FECA NUMBER	
15 INSURED'S CITY		16 INSURED'S STATE	
17 INSURED'S ZIP CODE		18 INSURED'S TELEPHONE (Include Area Code)	
19 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		20 OTHER INSURED'S POLICY GROUP OR GROUP NUMBER	
21 OTHER INSURED'S DATE OF BIRTH		22 OTHER INSURED'S SEX	
23 EMPLOYER'S NAME OR SCHOOL NAME		24 INSURANCE PLAN NAME OR PROGRAM NAME	
25 INSURANCE PLAN NAME OR PROGRAM NAME		26 IS THERE ANOTHER HEALTH BENEFIT PLAN?	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

17 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I do not request payment of government benefits either to myself or to the party who accepts assignment.

SIGNATURE ON FILE

DATE

SIGNATURE ON FILE

14 DATE OF CURRENT ILLNESS IF (no symptoms) OR INJURY (Accident) OR PREGNANCY (LMP)		15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		19 OUTSIDE LAB CHARGES	
20 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line)		21 MEDICAID RESUBMISSION CODE		22 PRIOR AUTHORIZATION NUMBER	

A	B	C	D	E	F	G	H	I	J
DATE(S) OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS	CHARGES	DATE OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS	CHARGES
05 01 12 05 01 12 1	90847	1	160 00	2	NPI	1871621060	1376864363		
05 03 12 05 03 12 1	90847	1	160 00	2	NPI	1871621060	1376864363		
05 05 12 05 05 12 1	90847	1	160 00	2	NPI	1871621060	1376864363		
05 06 12 05 06 12 1	90847	1	160 00	2	NPI	1871621060	1376864363		
05 08 12 05 08 12 1	90847	1	160 00	2	NPI	1871621060	1376864363		
05 10 12 05 10 12 1	90847	1	160 00	2	NPI	1871621060	1376864363		

24 FEDERAL TAX ID NUMBER	25 PATIENT'S ACCOUNT NO	26 ACCEPT ASSIGNMENT?	27 TOTAL CHARGE	28 AMOUNT PAID	29 BALANCE DUE
Redacted		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	\$ 960 00	\$	\$ 960 00
30 SIGNATURE OF PHYSICIAN OR SUPPLIER		31 SERVICE FACILITY LOCATION INFORMATION		32 BILLING PROVIDER INFO & PH #	
ELLIS COUNTY COMMUNITY		625 JEALOUSE WAY # 116		ELLIS COUNTY COMMUNITY SERVICES, INC	
CEDAR HILL TX 75104		CEDAR HILL TX 75104		CEDAR HILL TX 75104	
06 25 2012		1376864363		1376864363 216914601	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE 02/95

TEXAS MEDICAL CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

PICA

1 MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>		10 INSURED'S ID NUMBER (For Program in Item 1)	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		3 PATIENT'S BIRTH DATE	
Redacted		Redacted	
4 PATIENT'S ADDRESS (No. Street)		5 PATIENT'S RELATIONSHIP TO INSURED	
Redacted		Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6 CITY		7 INSURED'S ADDRESS (No. Street)	
ABILENE		Redacted	
8 STATE		9 PATIENT STATUS	
TX		Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
11 ZIP CODE		12 INSURED'S NAME (Last Name, First Name, Middle Initial)	
79605		Redacted	
13 TELEPHONE (Include Area Code)		14 INSURED'S DATE OF BIRTH	
()		Redacted	
15 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		16 IS PATIENT'S CONDITION RELATED TO	
		a EMPLOYMENT? (Current or Previous)	
		b AUTO ACCIDENT? PLACE (State)	
		c OTHER ACCIDENT?	
17 OTHER INSURED'S POLICY OR GROUP NUMBER		18 INSURED'S POLICY GROUP OR FECA NUMBER	
19 OTHER INSURED'S DATE OF BIRTH		20 INSURED'S DATE OF BIRTH	
MM DD YY		MM DD YY	
SEX		SEX	
M <input type="checkbox"/> F <input type="checkbox"/>		M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
21 EMPLOYER'S NAME OR SCHOOL NAME		22 EMPLOYER'S NAME OR SCHOOL NAME	
23 INSURANCE PLAN NAME OR PROGRAM NAME		24 IS THERE ANOTHER HEALTH BENEFIT PLAN?	
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 and	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

DATE

SIGNED SIGNATURE ON FILE

14 DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP)		15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
MM DD YY		MM DD YY		FROM TO	
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		20 OUTSIDE LAB? CHARGES	
17a NP		FROM TO		YES <input type="checkbox"/> NO <input type="checkbox"/>	
19 RESERVED FOR LOCAL USE		22 MEDICAID RESUBMISSION CODE OR GINAL REF NO		23 PRIOR AUTHORIZATION NUMBER	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)		3			
309 28					

A DATES OF SERVICE		B	C	D PROCEDURES, SERVICES, OR SUPPLIES	E	F	G	H	I	J
From	To	PLACE OF SERVICE	ENG	(Explain Unusual Circumstances)	DIAGNOSIS	CHARGES	DATE	TIME	QUANTITY	RENDERING PROVIDER ID #
MM DD YY	MM DD YY			CPT, HCPCS MODIFIER	NUMBER					
05 12 12	05 12 12	1		90847	1	160 00	2			1871621060
05 13 12	05 13 12	1		90847	1	160 00	2			1376864363
05 15 12	05 15 12	1		90847	1	160 00	2			1871621060
05 17 12	05 17 12	1		90847	1	160 00	2			1376864363
05 19 12	05 19 12	1		90847	1	160 00	2			1871621060
05 20 12	05 20 12	1		90847	1	160 00	2			1376864363

24 FEDERAL TAX ID NUMBER		25 PATIENT'S ACCOUNT NO		26 ACCEPT ASSIGNMENT?		27 TOTAL CHARGE		28 AMOUNT PAID		29 BALANCE DUE	
Redacted				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		\$ 960 00		\$		\$ 960 00	
30 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS				31 SERVICE FACILITY LOCATION INFORMATION				32 BILLING PROVIDER INFO & PH #			
06 25 2012				ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104				ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104			
SIGNED				DATE				1376864363			
								1376864363 216914601			

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/05

TEXAS MEDICAID & HEALTH CARE
CLAIMSPO BOX
AUSTIN TX 78720-0735

MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) <input checked="" type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Tricare #) <input checked="" type="checkbox"/> (Tricare #) CHAMPVA <input type="checkbox"/> (Champus #) <input checked="" type="checkbox"/> (Champus #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input checked="" type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (FECA #) <input checked="" type="checkbox"/> (FECA #) OTHER <input type="checkbox"/> (Other #) <input checked="" type="checkbox"/> (Other #)		13 INSURED'S ID NUMBER Redacted	
1 PATIENT'S NAME (Last, First, Middle Initial) Redacted		2 INSURED'S NAME (Last, First, Middle Initial) Redacted	
3 PATIENT'S BIRTH DATE Redacted		4 INSURED'S BIRTH DATE Redacted	
5 PATIENT'S SEX Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		6 INSURED'S SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
7 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8 INSURED'S ADDRESS (No. Street) Redacted	
9 CITY ABILENE		10 STATE TX	
11 ZIP CODE 79605		12 TELEPHONE (Include Area Code) ()	
13 OTHER INSURED'S NAME (Last, First, Middle Initial) Redacted		14 IS PATIENT'S CONDITION RELATED TO Employment <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>	
15 OTHER INSURED'S POLICY OR GROUP NUMBER Redacted		16 INSURED'S POLICY GROUP OR FECA NUMBER Redacted	
17 OTHER INSURED'S DATE OF BIRTH MM DD YY		18 INSURED'S DATE OF BIRTH Redacted	
19 OTHER INSURED'S SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		20 INSURED'S SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
21 EMPLOYER'S NAME OR SCHOOL NAME Redacted		22 EMPLOYER'S NAME OR SCHOOL NAME Redacted	
23 INSURANCE PLAN NAME OR PROGRAM NAME Redacted		24 INSURANCE PLAN NAME OR PROGRAM NAME Redacted	
25 IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, return to and complete item 9 and 10.		26 IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, return to and complete item 9 and 10.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 27 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefit to either myself or to the party who accepts assignment below.) SIGNED: _____ DATE: _____			
28 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: _____ DATE: _____			
29 DATE OF CURRENT ILLNESS OR INJURY (Accident or Pregnancy/ILMP) MM DD YY		30 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
31 NAME OF REFERRING PROVIDER OR OTHER SOURCE Redacted		32 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: MM DD YY TO: MM DD YY	
33 RESERVED FOR LOCAL USE		34 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
35 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line) 309 28		36 MEDICAID RESUBMISSION CODE OR ORIGINAL REF NO. Redacted	
37 PRIOR AUTHORIZATION NUMBER Redacted		38 MEDICAID RESUBMISSION CODE OR ORIGINAL REF NO. Redacted	
39 DATE(S) OF SERVICE From: MM DD YY To: MM DD YY			
40 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			
41 DIAGNOSIS POINTER Redacted			
42 S CHARGES Redacted			
43 RENDER NO PROVIDER ID # Redacted			
44 FEDERAL TAX ID NUMBER Redacted			
45 PATIENT'S ACCOUNT NO Redacted			
46 ACCEPT ASSIGNMENT? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
47 TOTAL CHARGE \$ 480.00			
48 AMOUNT PAID \$ 480.00			
49 BALANCE DUE \$ 480.00			
50 SIGNATURE OF PHYSICIAN OR SUPPLIER (Include NO DEGREES OR CREDENTIALS if provider is not a physician or supplier) Redacted		51 SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	
52 BILLING PROVIDER INFO & PH # Redacted		53 BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	
54 SIGNED Redacted		55 DATE 06 25 2012	
56 SIGNED Redacted		57 DATE 06 25 2012	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Printed on: 6/17/2012 5:11:59 PM

Patient Information

Parent's Name: [REDACTED]
DOB: [REDACTED]
Gender: F
Age: [REDACTED]
Name: [REDACTED]
Address: [REDACTED] ABILENE, TX 79605
County: Taylor
Medicare No.: [REDACTED]
Social Sec. No.: [REDACTED]

Inquiry Information

NPI/APL: 1619203361
Eligibility From: 3/1/2012
Eligibility Through: 3/31/2012
Medicaid/Client No.: [REDACTED]
Social Security Number: [REDACTED]
Date of Birth: [REDACTED]
Last Name: [REDACTED]
First Name: [REDACTED]

Eligibility Segments

Effective Date	Medical Coverage	Program Type	Program	Benefit Plan	Spend-down Indicator
EFF : 3/1/2012 TRM : 6/30/2012 ADD : 4/2/2012	43 RIBICOFF CHILDREN UNDER AGE 4 WITH INC	REGULAR	R	100 - TRADITIONAL MEDICAID	

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

No Managed Care Segments found

Limits Segments

Effective Date	Health Plan	TPR Status	TPR Date	TPR Reason
1/15/2011				3/4/2010

1000200302012117345935303 / Paid

EXHIBIT

16

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/23

PICA

CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

MED CARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK (LAW) <input type="checkbox"/> OTHER <input type="checkbox"/>		1a INSURED'S ID NUMBER Redacted	
2 PATIENT'S NAME (Last, First, Middle Initial) Redacted		3 PATIENT'S BIRTH DATE Redacted	
5 PATIENT'S ADDRESS (No. Street) Redacted		6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
4 OTHER INSURED'S NAME (Last, First, Middle Initial)		7 INSURED'S ADDRESS (No. Street) Redacted	
8 PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input checked="" type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		CITY KEMAH	
STATE TX		STATE TX	
ZIP CODE 77565		ZIP CODE 77565	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
9 OTHER INSURED'S POLICY OR GROUP NUMBER		10 IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
11 INSURED'S POLICY GROUP OR FECA NUMBER		12 INSURED'S DATE OF BIRTH MM DD YY Redacted	
13 INSURED'S DATE OF BIRTH MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		14 EMPLOYER'S NAME OR SCHOOL NAME	
15 INSURANCE PLAN NAME OR PROGRAM NAME		16 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 and 10	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
17 PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

SIGNATURE ON FILE

DATE

SIGNED

SIGNATURE ON FILE

18 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		19 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		20 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI		22 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		23 OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO	
24 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Review Items 1, 2, 3 or 4 to Item 24E by Line) 309 28		25 MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		26 PRIOR AUTHORIZATION NUMBER	
27 DATE(S) OF SERVICE From MM DD YY To MM DD YY		28 PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		29 DIAGNOSIS POINTER	
30 S CHARGES		31 DAYS OF CARE		32 RENDERING PROVIDER ID	
1 05 29 12 05 29 12 1 90847 1 160 00 2 1871621060				NPI 1376864363	
2 05 31 12 05 31 12 1 90847 1 160 00 2 1871621060				NPI 1376864363	
3				NPI	
4				NPI	
5				NPI	
6				NPI	

29 FEDERAL TAX ID NUMBER Redacted	30 SSN EIN <input checked="" type="checkbox"/>	31 PATIENT'S ACCOUNT NO	32 ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	33 TOTAL CHARGE \$ 320 00	34 AMOUNT PAID \$	35 BALANCE DUE \$ 320 00
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36 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this form are true and correct.) 06 25 2012	37 SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	38 BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104
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SIGNED	DATE	1376864363	1376864363	216914601
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Printed on: 6/17/2012 5:46:15 PM

Patient Information

SSN	[REDACTED]
DOB	[REDACTED]
Gender	M
Address	[REDACTED]
City	[REDACTED]
State	[REDACTED]
Zip	[REDACTED]
County	Galveston
Medicaid No.	[REDACTED]
Medicaid Type	INDIV OUTS

Inquiry Information

NPI/ACT	1619203351
Eligibility From	5/8/2012
Eligibility Through	5/31/2012
Medicaid / Client No.	[REDACTED]
Social Security Number	[REDACTED]
Date of Birth	[REDACTED]
Last Name	[REDACTED]
First Name	[REDACTED]

Eligibility Segments

Effective Date	Termination Date	Eligibility Type	Program	Benefit Plan	Segment Code
EFF: 1/1/2011	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	
TRM: 6/30/2012					
ADD: 11/20/2010					

Medicare Segments

No Medicare Segments found

*May 29, 31 90847
1871621060*

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

Effective Date	Termination Date	Managed Care Plan
EFF: 3/1/2012	DELTA DENTAL	
TRM: 6/30/2012		
ADD: 1/25/2012		
EFF: 3/1/2012	DELTA DENTAL	
TRM: 6/30/2012		
ADD: 1/25/2012		

Limits Segments

Effective Date	Termination Date	Limit Type	Limit Amount
7/24/2009			
			11/9/2011

100020030201217345933458 / Paid

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/03

PICA

MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Spouse's SSN) <input type="checkbox"/> CHAMPVA (Military ID) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK/LUNG (SSN) <input type="checkbox"/> OTHER (ID)		13 INSURED'S ID NUMBER Redacted	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		4 INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted	
5 PATIENT'S ADDRESS (No. Street) Redacted		7 INSURED'S ADDRESS (No. Street) Redacted	
CITY BAYTOWN		CITY BAYTOWN	
STATE TX		STATE TX	
ZIP CODE 77523		ZIP CODE 77523	
TELEPHONE (Include Area Code) ()		TELEPHONE (Include Area Code) ()	
6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8 PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10 IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>	
11 INSURED'S POLICY GROUP OR FECA NUMBER		12 INSURED'S DATE OF BIRTH Redacted	
13 INSURED'S DATE OF BIRTH MM DD YY		14 INSURED'S SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
15 EMPLOYER'S NAME OR SCHOOL NAME		16 EMPLOYER'S NAME OR SCHOOL NAME	
17 INSURANCE PLAN NAME OR PROGRAM NAME		18 INSURANCE PLAN NAME OR PROGRAM NAME	
19 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		22 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
23 SIGNATURE ON FILE		24 SIGNATURE ON FILE	
25 DATE OF CURRENT ILLNESS (If patient has same or similar illness, give first date)		26 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
27 NAME OF REFERRING PROVIDER OR OTHER SOURCE		28 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
29 RESERVED FOR LOCAL USE		29 OUTSIDE LAB CHARGES	
30 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Recode items 1, 2, 3 or 4 to item 24E by Line)		31 MEDICAID RESUBMISSION CODE	
309 28		32 PRIOR AUTHORIZATION NUMBER	
33 DATE(S) OF SERVICE		34 PROCEDURES, SERVICES, OR SUPPLIES	
35 PLACE OF SERVICE		36 DIAGNOSIS POINTER	
37 S CHARGES		38 DAYS OF LAST	
39 H CHARGES		40 I CHARGES	
41 J CHARGES		42 RENDERING PROVIDER ID	
43 FEDERAL TAX ID NUMBER		44 PATIENT'S ACCOUNT NO.	
45 SIGNATURE OF PHYSICIAN OR SUPPLIER		46 ACCEPT ASSIGNMENT?	
47 SERVICE FACILITY LOCATION INFORMATION		48 TOTAL CHARGE	
49 BILLING PROVIDER INFO & PH		50 AMOUNT PAID	
51 BALANCE DUE		52 SERVICE FACILITY LOCATION INFORMATION	
53 BILLING PROVIDER INFO & PH		54 AMOUNT PAID	
55 BALANCE DUE		56 SERVICE FACILITY LOCATION INFORMATION	
57 BILLING PROVIDER INFO & PH		58 AMOUNT PAID	
59 BALANCE DUE		60 SERVICE FACILITY LOCATION INFORMATION	
61 BILLING PROVIDER INFO & PH		62 AMOUNT PAID	
63 BALANCE DUE		64 SERVICE FACILITY LOCATION INFORMATION	
65 BILLING PROVIDER INFO & PH		66 AMOUNT PAID	
67 BALANCE DUE		68 SERVICE FACILITY LOCATION INFORMATION	
69 BILLING PROVIDER INFO & PH		70 AMOUNT PAID	
71 BALANCE DUE		72 SERVICE FACILITY LOCATION INFORMATION	
73 BILLING PROVIDER INFO & PH		74 AMOUNT PAID	
75 BALANCE DUE		76 SERVICE FACILITY LOCATION INFORMATION	
77 BILLING PROVIDER INFO & PH		78 AMOUNT PAID	
79 BALANCE DUE		80 SERVICE FACILITY LOCATION INFORMATION	
81 BILLING PROVIDER INFO & PH		82 AMOUNT PAID	
83 BALANCE DUE		84 SERVICE FACILITY LOCATION INFORMATION	
85 BILLING PROVIDER INFO & PH		86 AMOUNT PAID	
87 BALANCE DUE		88 SERVICE FACILITY LOCATION INFORMATION	
89 BILLING PROVIDER INFO & PH		90 AMOUNT PAID	
91 BALANCE DUE		92 SERVICE FACILITY LOCATION INFORMATION	
93 BILLING PROVIDER INFO & PH		94 AMOUNT PAID	
95 BALANCE DUE		96 SERVICE FACILITY LOCATION INFORMATION	
97 BILLING PROVIDER INFO & PH		98 AMOUNT PAID	
99 BALANCE DUE		100 SERVICE FACILITY LOCATION INFORMATION	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03.05

CLAIMS

PO BOX

AUSTIN TX 78720-0735

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		1. INSURED'S ID. NUMBER Redacted	
2. PATIENT'S NAME (Last, First Name, Middle Initial) Redacted		3. PATIENT'S BIRTH DATE Redacted	
4. PATIENT'S ADDRESS (No. Street) Redacted		5. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. CITY BAYTOWN		7. INSURED'S ADDRESS (No. Street) Redacted	
8. STATE TX		9. CITY BAYTOWN	
10. ZIP CODE 77523		11. STATE TX	
12. TELEPHONE (Include Area Code) ()		13. ZIP CODE 77523	
14. TELEPHONE (Include Area Code) ()		15. INSURED'S POLICY GROUP OR FECA NUMBER	
16. OTHER INSURED'S NAME (Last, First Name, Middle Initial)		17. INSURED'S DATE OF BIRTH Redacted	
18. OTHER INSURED'S POLICY OR GROUP NUMBER		19. EMPLOYER'S NAME OR SCHOOL NAME	
20. OTHER INSURED'S DATE OF BIRTH MM DD YY		21. EMPLOYER'S NAME OR SCHOOL NAME	
22. SEX M <input type="checkbox"/> F <input type="checkbox"/>		23. INSURANCE PLAN NAME OR PROGRAM NAME	
24. EMPLOYER'S NAME OR SCHOOL NAME		25. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 9 and 10	
26. INSURANCE PLAN NAME OR PROGRAM NAME		27. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
28. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		29. SIGNATURE ON FILE	
30. DATE OF CURRENT ILLNESS (If not symptoms or injury (Accident) or pregnancy, LMP)		31. DATE	
32. NAME OF REFERRING PROVIDER OR OTHER SOURCE		33. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
34. RESERVED FOR LOCAL USE		35. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Route items 1, 2, 3 or 4 to item 24E by line)		37. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
38. 309 28		39. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
40. MEDICAID RESUBMISSION CODE		41. ORIGINAL REF NO	
42. PRIOR AUTHORIZATION NUMBER		43. DATES OF SERVICE From MM DD YY To MM DD YY	
44. PLACED SERVICE ENG		45. D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT HCPCS MODIFIER	
46. DIAGNOSIS POINTER		47. CHARGES	
48. REFERRING PROVIDER ID		49. NPI	
50. 04 16 12 04 16 12 1 90847		51. 1 160 00 2 1871621060	
52. 04 18 12 04 18 12 1 90847		53. 1 160 00 2 1871621060	
54. 04 20 12 04 20 12 1 90847		55. 1 160 00 2 1871621060	
56. 04 23 12 04 23 12 1 90847		57. 1 160 00 2 1871621060	
58. 04 25 12 04 25 12 1 90847		59. 1 160 00 2 1871621060	
60. 04 27 12 04 27 12 1 90847		61. 1 160 00 2 1871621060	
62. FEDERAL TAX ID NUMBER		63. PATIENT'S ACCOUNT NO	
64. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS		65. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
66. SERVICE FACILITY LOCATION INFORMATION		67. TOTAL CHARGE \$ 960 00	
68. ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		69. AMOUNT PAID \$ 960 00	
70. BILLING PROVIDER INFO & PH#		71. BALANCE DUE \$	
72. ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		73. 1376864363 216914601	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/05

PO BOX

AUSTIN

AUSTIN TX 78720-0735

Form 100-010 (Rev. 10-01-00) - MEDICAID CHAMPVA GROUP HEALTH PLAN FECA BILLING ORDER

1. PATIENT'S NAME (Last, First, Middle Initial): Redacted

2. PATIENT'S ADDRESS (No. Street): Redacted

3. CITY: BAYTOWN

4. STATE: TX

5. ZIP CODE: 77523

6. TELEPHONE (Include Area Code): ()

7. PATIENT'S BIRTH DATE: Redacted

8. SEX: ☒ M ☐ F

9. PATIENT RELATIONSHIP TO INSURED: ☒ Self ☐ Spouse ☐ Child ☐ Other

10. PATIENT STATUS: ☒ Single ☐ Married ☐ Other

11. EMPLOYED: ☐ Full-Time Student ☒ Part-Time Student

12. IS PATIENT'S CONDITION RELATED TO: ☐ YES ☐ NO

13. EMPLOYMENT? (Current or Previous): ☐ YES ☐ NO

14. AUTO ACCIDENT? ☐ YES ☐ NO

15. OTHER ACCIDENT? ☐ YES ☐ NO

16. RESERVED FOR LOCAL USE

17. INSURED'S NAME (Last, First, Middle Initial): Redacted

18. INSURED'S ADDRESS (No. Street): Redacted

19. CITY: BAYTOWN

20. STATE: TX

21. ZIP CODE: 77523

22. TELEPHONE (Include Area Code): ()

23. INSURED'S POLICY GROUP OR FECA NUMBER

24. INSURED'S DATE OF BIRTH: Redacted

25. SEX: ☒ M ☐ F

26. EMPLOYER'S NAME OR SCHOOL NAME

27. INSURANCE PLAN NAME OR PROGRAM NAME

28. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO

29. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: Redacted

30. SIGNATURE ON FILE

31. DATE

32. DATE OF CURRENT ILLNESS (If not symptoms or injury (accident or pregnancy/ILMP))

33. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

34. NAME OF REFERRING PROVIDER OR OTHER SOURCE

35. RESERVED FOR LOCAL USE

36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

37. DATE OF SERVICE

38. PLACE OF SERVICE

39. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances)

40. DIAGNOSIS POINTER

41. S CHARGES

42. MEDICAID RESUBMISSION CODE

43. PRIOR AUTHORIZATION NUMBER

44. SIGNATURE OF PHYSICIAN OR SUPPLIER

45. SIGNATURE OF PATIENT

46. PATIENT'S ACCOUNT NO

47. ACCEPT ASSIGNMENT? ☒ YES ☐ NO

48. TOTAL CHARGE

49. AMOUNT PAID

50. BALANCE DUE

51. SERVICE FACILITY LOCATION INFORMATION

52. BILLING PROVIDER INFO & PH #

53. BILLING PROVIDER INFO & PH #

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213. BILLING PROVIDER INFO & PH #

214.



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 6/24/2012 1:19:42 PM

Patient Information

First Name	[REDACTED]
Last Name	[REDACTED]
DOB	[REDACTED]
Gender	M
Address	[REDACTED]
City	[REDACTED]
State	TX
Zip	77522
Chambers	[REDACTED]

Inquiry Information

AP/APP	1519203351
Eligibility From	4/1/2012
Eligibility Through	4/30/2012
Medicaid Group	[REDACTED]
Social Security Number	[REDACTED]
Date of Birth	[REDACTED]
Last Name	[REDACTED]
First Name	[REDACTED]

Eligibility Segments

EFF	TRM	ADD	48 RIBICOFF CHILDREN UNDER AGE 4 WITH INC	REGULAR	R	100 - TRADITIONAL MEDICAID
3/1/2012	6/30/2012	4/5/2012				

30

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

No Managed Care Segments found

Limits Segments

11/4/2011

AP 11/1
2,4,6
9,11,13
16,18,20
23,25,27
30, 187, 162, 1060

44-100020030201218147798881

/paid

MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input checked="" type="checkbox"/> (Medicaid #)		TRICARE CHAMPUS (Sponsor's SSN)		CHAMPVA (Member ID)		GROUP HEALTH PLAN (SSN or ID)		FECA BLK/LONG (SSN)		OTHER (ID)		1a INSURED'S ID NUMBER Redacted									
2 PATIENT'S NAME (Last, First, Middle Initial) Redacted												3 PATIENT'S BIRTH DATE Redacted		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4 INSURED'S NAME (Last, First, Middle Initial) Redacted							
5 PATIENT'S ADDRESS (No. Street) Redacted												6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7 INSURED'S ADDRESS (No. Street) Redacted									
CITY FREDERICKSBURG												STATE TX		CITY FREDERICKSBURG		STATE TX							
ZIP CODE 78624												TELEPHONE (Include Area Code) ()		ZIP CODE 78624		TELEPHONE (Include Area Code) ()							
8 OTHER INSURED'S NAME (Last, First, Middle Initial)												9 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10a RESERVED FOR LOCAL USE		11 INSURED'S POLICY GROUP OR FECA NUMBER									
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits, either to myself or to the party who accepts assignment.) SIGNED Redacted												13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED Redacted											
14 DATE OF CURRENT ILLNESS IF "a" symptoms OR INJURY (accident OR PREGNANCY) (MM/DD/YY)												15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM/DD/YY)		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)									
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE												18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)		19 RESERVED FOR LOCAL USE									
20 OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO												21 MEDICAID RESUBMISSION CODE		22 PRIOR AUTHORIZATION NUMBER									
23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer items 1, 2, 3 or 4 to item 24E by line) 309 28												24 A DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)		24 B PLACE OF SERVICE (CPT, HCPCS, MODIFIER)		24 C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		24 D DIAGNOSIS (ICD-9-CM)		24 E CHARGES		24 F RENDER NO. PROVIDER ID	
1 03 02 12 03 02 12 1 90847 1 160 00 2 1871621060												2 03 05 12 03 05 12 1 90847 1 160 00 2 1871621060		3 03 07 12 03 07 12 1 90847 1 160 00 2 1871621060		4 03 09 12 03 09 12 1 90847 1 160 00 2 1871621060		5 03 12 12 03 12 12 1 90847 1 160 00 2 1871621060		6 03 14 12 03 14 12 1 90847 1 160 00 2 1871621060			
25 FEDERAL TAX ID NUMBER Redacted												26 PATIENT'S ACCOUNT NO.		27 ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28 TOTAL CHARGE \$ 960 00		29 AMOUNT PAID \$		30 BALANCE DUE \$ 960 00			
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS DATE 06 04 2012												32 SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		33 BILLING PROVIDER INFO & PH. ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104									

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02-05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		1. INSURED'S ID NUMBER Redacted	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		3. PATIENT'S BIRTH DATE Redacted	
4. PATIENT'S ADDRESS (No. Street) Redacted		5. INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted	
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street) Redacted	
8. CITY FREDERICKSBURG		9. STATE TX	
10. ZIP CODE 78624		11. TELEPHONE (Include Area Code) ()	
12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted		13. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. OTHER INSURED'S POLICY OR GROUP NUMBER Redacted		15. INSURED'S POLICY GROUP OR FECA NUMBER Redacted	
16. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		17. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
18. EMPLOYER'S NAME OR SCHOOL NAME Redacted		19. EMPLOYER'S NAME OR SCHOOL NAME Redacted	
20. INSURANCE PLAN NAME OR PROGRAM NAME Redacted		21. INSURANCE PLAN NAME OR PROGRAM NAME Redacted	
22. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, return to and complete item 21.		23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) Redacted	
24. SIGNATURE ON FILE SIGNED _____ DATE _____		25. SIGNATURE ON FILE SIGNED _____ DATE _____	
26. DATE OF CURRENT ILLNESS (If not yet determined or injury/accident, OR PREGNANCY/EMP) MM DD YY		27. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
28. NAME OF REFERRING PROVIDER OR OTHER SOURCE Redacted		29. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
30. RESERVED FOR LOCAL USE		31. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
32. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Use items 1, 2, 3 or 4 to item 24E by Line) 309 28		33. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
34. PRIOR AUTHORIZATION NUMBER		35. CHARGES \$ 960.00	
36. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 16 12 03 16 12		37. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS MODIFIER 90847	
38. DIAGNOSIS POINTER 1		39. CHARGES \$ 160.00	
40. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS Redacted		41. SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	
42. BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		43. BALANCE DUE \$ 960.00	
44. SIGNATURE Redacted		45. DATE 06 04 2012	
46. SIGNATURE Redacted		47. DATE 06 04 2012	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

TEXAS MEDICAID & HEALTHCARE

CLAIMS

PO BOX

AUSTIN TX 78720-0735

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/05

HICA

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BULKING <input type="checkbox"/> OTHER		13 INSURED'S ID NUMBER Redacted	
4 PATIENT'S BIRTH DATE Redacted		5 PATIENT'S SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
6 PATIENT'S ADDRESS (No. Street) Redacted		7 INSURED'S ADDRESS (No. Street) Redacted	
8 CITY FREDERICKSBURG		9 STATE TX	
10 ZIP CODE 78624		11 TELEPHONE (Include Area Code) ()	
12 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted		13 INSURED'S POLICY GROUP OR FECA NUMBER Redacted	
14 OTHER INSURED'S DATE OF BIRTH MM DD YY		15 INSURED'S DATE OF BIRTH Redacted	
16 EMPLOYER'S NAME OR SCHOOL NAME Redacted		17 EMPLOYER'S NAME OR SCHOOL NAME Redacted	
18 INSURANCE PLAN NAME OR PROGRAM NAME Redacted		19 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED SIGNATURE ON FILE

DATE

14 DATE OF CURRENT ILLNESS (If not symptoms OR INJURY (Accident) OR PREGNANCY (LMP))

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

19 RESERVED FOR LOCAL USE

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

309 28

3

24 DATE(S) OF SERVICE

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LL

LM

EHS



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 3/12/2012 3:43:25 PM

Patient Information

DOB	[REDACTED]
Gender	F
SSN	[REDACTED]
Address	[REDACTED]
City	FREDERICKSBURG, TX 78624
County	Gillespie
Phone No.	[REDACTED]
Category	INDIV OUTS

Inquiry Information

NP/OP	1376864363
Eligibility Start	3/1/2012
Eligibility Through	3/9/2012
Medicaid / Change No.	[REDACTED]
Social Security Number	[REDACTED]
Date of Birth	[REDACTED]
Last Name	[REDACTED]
First Name	[REDACTED]

Eligibility Segments

Effective Date	Termination Date	Program Type	Program	Benefit Plan	Specialty
EFF: 9/1/2011	13 SSI, RECIPIENT	REGULAR	R	100 - TRADITIONAL MEDICAID	
TRM: 3/31/2012					
ADD: 8/22/2011					

30

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

March
5/7/9
12/14/16
19/21/23
26/28/30
2

code
90847
1871621060

TPR Segments

Effective Date	Termination Date	Address	Phone	Additional Information
EFF: 9/1/2010	TRM: 12/31/1999	[REDACTED]	[REDACTED]	Insurance Company: [REDACTED] Insured's ID No. / SSN: [REDACTED] Relation: [REDACTED] Employer: [REDACTED] Group: [REDACTED] Coverage Code: [REDACTED]

TPL Segments

No TPL Segments found

Managed Care Segments

Effective Date	Termination Date	Organization	Address	Phone
EFF: 3/1/2012	TRM: 3/31/2012	DENTAQUEST	[REDACTED]	[REDACTED]
ADD: 2/14/2012				
EFF: 3/1/2012	TRM: 3/31/2012	DENTAQUEST	[REDACTED]	[REDACTED]
ADD: 2/14/2012				

Limits Segments

Effective Date	Termination Date	Program	Program	Medical
3/30/2011	11/22/2011			3/30/2010

100020030201215340027652

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03.95

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicare #)		TRICARE <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (Member ID)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA <input type="checkbox"/> (SSN)		OTHER <input type="checkbox"/> (ID)		12. INSURED'S ID. NUMBER (For Programs in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S BIRTH DATE		SEX		6. INSURED'S ADDRESS (No., Street)	
7. PATIENT'S ADDRESS (No., Street)		8. PATIENT RELATIONSHIP TO INSURED		9. INSURED'S ADDRESS (No., Street)		10. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH		SEX		12. EMPLOYER'S NAME OR SCHOOL NAME	
13. CITY		STATE		14. PATIENT STATUS		15. CITY		STATE		16. ZIP CODE		TELEPHONE (Include Area Code)	
17. ZIP CODE		18. TELEPHONE (Include Area Code)		19. EMPLOYED <input type="checkbox"/> Full-Time <input checked="" type="checkbox"/> Part-Time <input type="checkbox"/> Student		20. ZIP CODE		21. TELEPHONE (Include Area Code)		22. EMPLOYER'S NAME OR SCHOOL NAME		23. INSURANCE PLAN NAME OR PROGRAM NAME	
24. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		25. IS PATIENT'S CONDITION RELATED TO:		26. EMPLOYMENT? (Current or Previous)		27. INSURED'S DATE OF BIRTH		SEX		28. EMPLOYER'S NAME OR SCHOOL NAME		29. INSURANCE PLAN NAME OR PROGRAM NAME	
30. OTHER INSURED'S POLICY OR GROUP NUMBER		31. YES <input type="checkbox"/> NO <input type="checkbox"/>		32. YES <input type="checkbox"/> NO <input type="checkbox"/>		33. YES <input type="checkbox"/> NO <input type="checkbox"/>		34. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		35. YES <input type="checkbox"/> NO <input type="checkbox"/>		36. YES <input type="checkbox"/> NO <input type="checkbox"/>	
37. OTHER INSURED'S DATE OF BIRTH		38. AUTO ACCIDENT?		39. PLACE (State)		40. YES <input type="checkbox"/> NO <input type="checkbox"/>		41. YES <input type="checkbox"/> NO <input type="checkbox"/>		42. YES <input type="checkbox"/> NO <input type="checkbox"/>		43. YES <input type="checkbox"/> NO <input type="checkbox"/>	
44. EMPLOYER'S NAME OR SCHOOL NAME		45. OTHER ACCIDENT?		46. YES <input type="checkbox"/> NO <input type="checkbox"/>		47. YES <input type="checkbox"/> NO <input type="checkbox"/>		48. YES <input type="checkbox"/> NO <input type="checkbox"/>		49. YES <input type="checkbox"/> NO <input type="checkbox"/>		50. YES <input type="checkbox"/> NO <input type="checkbox"/>	
51. INSURANCE PLAN NAME OR PROGRAM NAME		52. RESERVED FOR LOCAL USE		53. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		54. YES <input type="checkbox"/> NO <input type="checkbox"/>		55. YES <input type="checkbox"/> NO <input type="checkbox"/>		56. YES <input type="checkbox"/> NO <input type="checkbox"/>		57. YES <input type="checkbox"/> NO <input type="checkbox"/>	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												58. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment of benefits.)												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)	
SIGNATURE ON FILE												SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP)												15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION												17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE												19. OUTSIDE LAB? \$ CHARGES	
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24 by Line)												21. MEDICAID RESUBMISSION CODE	
22. PRIOR AUTHORIZATION NUMBER												23. ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE												25. B. C. D. PROCEDURES, SERVICES, OR SUPPLIES	
26. E. DIAGNOSIS POINTER												27. F. CHARGES	
28. G. DAYS ON LEAVE												29. H. I. J. RENDERING PROVIDER ID #	
1. 04 02 12 04 02 12 1 90847 1 160 00 2 NPI 1871621060												1376864363	
2. 04 04 12 04 04 12 1 90847 1 160 00 2 NPI 1871621060												1376864363	
3. 04 06 12 04 06 12 1 90847 1 160 00 2 NPI 1871621060												1376864363	
4. 04 09 12 04 09 12 1 90847 1 160 00 2 NPI 1871621060												1376864363	
5. 04 11 12 04 11 12 1 90847 1 160 00 2 NPI 1871621060												1376864363	
6. 04 13 12 04 13 12 1 90847 1 160 00 2 NPI 1871621060												1376864363	
25. FEDERAL TAX ID NUMBER												26. PATIENT'S ACCOUNT NO	
27. ACCEPT ASSIGNMENT?												28. TOTAL CHARGE	
29. AMOUNT PAID												30. BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER												32. SERVICE FACILITY LOCATION INFORMATION	
33. BILLING PROVIDER INFO & PH #												34. SIGNATURE OF PHYSICIAN OR SUPPLIER	
35. DATE												36. DATE	
37. SIGNATURE OF PHYSICIAN OR SUPPLIER												38. DATE	
39. SIGNATURE OF PHYSICIAN OR SUPPLIER												40. DATE	

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02.05

PICA

TEXAS MEDICAID & HEALTHCARE
CLAIMS
PO BOX
AUSTIN TX 78720-0735

PICA

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		12 INSURED'S I.D. NUMBER Redacted	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		3 PATIENT'S BIRTH DATE Redacted	
4 INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted		5 PATIENT'S ADDRESS (No. Street) Redacted	
6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7 INSURED'S ADDRESS (No. Street) Redacted	
8 PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9 INSURED'S POLICY GROUP OR FECA NUMBER Redacted	
10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11 INSURED'S DATE OF BIRTH Redacted	
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Redacted		13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Redacted	

14 DATE OF CURRENT ILLNESS (If first symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 04 16 12		15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY 04 18 12	
16 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI 17b NPI		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: MM DD YY TO: MM DD YY 04 16 12 TO 04 27 12	
19 RESERVED FOR LOCAL USE		20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Write items 1, 2, 3 or 4 to Item 24 by Line)		22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO.	

23 FEDERAL TAX ID NUMBER Redacted		24 PATIENT'S ACCOUNT NO. 1376864363	
25 ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		26 TOTAL CHARGE \$ 960.00	
27 AMOUNT PAID \$ 960.00		28 BALANCE DUE \$ 960.00	

A	B	C	D	E	F	G	H	I	J
DATE(S) OF SERVICE	PLACE OF SERVICE	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS	S CHARGES	DAY OF WEEK	TIME	QUAL	RENDERING PROVIDER ID	
04 16 12	1	90847	1	160.00	2			1871621060	
04 18 12	1	90847	1	160.00	2			1871621060	
04 20 12	1	90847	1	160.00	2			1871621060	
04 23 12	1	90847	1	160.00	2			1871621060	
04 25 12	1	90847	1	160.00	2			1871621060	
04 27 12	1	90847	1	160.00	2			1871621060	

29 SIGNATURE OF PHYSICIAN OR SUPPLIER Redacted		30 SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104	
31 BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		32 DATE 07 09 2012	

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/03

PICA

CLAIMS

PO BOX

AUSTIN TX 78720-0735

PICA

1 MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)		12 INSURED'S ID NUMBER (For Program in Item 1) Redacted
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Redacted		3 INSURED'S NAME (Last Name, First Name, Middle Initial) Redacted
4 PATIENT'S ADDRESS (No. Street) Redacted		5 INSURED'S ADDRESS (No. Street) Redacted
CITY TEMPLE	STATE TX	CITY TEMPLE
ZIP CODE 76501	TELEPHONE (Include Area Code) ()	ZIP CODE 76501
6 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7 INSURED'S POLICY GROUP OR FECA NUMBER
8 PATIENT'S STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input checked="" type="checkbox"/> Part-Time Student <input type="checkbox"/>		8 INSURED'S DATE OF BIRTH MM DD YY Redacted SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9 OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>
10 OTHER INSURED'S POLICY OR GROUP NUMBER		10 EMPLOYER'S NAME OR SCHOOL NAME
11 OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		11 INSURANCE PLAN NAME OR PROGRAM NAME
12 EMPLOYER'S NAME OR SCHOOL NAME		12 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d
13 INSURANCE PLAN NAME OR PROGRAM NAME		13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Authorizes payment of medical benefits to the undersigned physician or supplier for services described below)
14 RESERVED FOR LOCAL USE		SIGNED

14 DATE OF CURRENT ILLNESS (First symptoms) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a	17b NPI
18 RESERVED FOR LOCAL USE		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to items 1, 2, 3 or 4 to item 24E by Line)		20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	

21 MEDICAID RESUBMISSION CODE		22 ORIGINAL REF NO
23 PRIOR AUTHORIZATION NUMBER		

A DATE(S) OF SERVICE		B PLACE OF SERVICE	C EMO	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E DIAGNOSIS POINTER	F \$ CHARGES	G DAYS CH UNITS	H ICD-9-CM	I CPT	J RENDERING PROVIDER ID			
04	26	12	04	26	12	1		90847	1	160 00	2	1871621060	1376864363
04	30	12	04	30	12	1		90847	1	160 00	2	1871621060	1376864363

25 FEDERAL TAX ID NUMBER Redacted	26 SSN EIN <input checked="" type="checkbox"/>	26 PATIENT'S ACCOUNT NO	27 ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28 TOTAL CHARGE \$ 320 00	29 AMOUNT PAID \$	30 BALANCE DUE \$ 320 00
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this claim and are made as a professional)		32 SERVICE FACILITY LOCATION INFORMATION ELLIS COUNTY COMMUNITY 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		33 BILLING PROVIDER INFO & PH # ELLIS COUNTY COMMUNITY SERVICES, INC 625 JEALOUSE WAY # 116 CEDAR HILL TX 75104		
SIGNED	DATE 07 09 2012	1376864363		1376864363	216914601	



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Printed on: 6/23/2012 5:22:44 PM

Patient Information

NAME	[REDACTED]
DOB	[REDACTED]
SEX	F
ADDRESS	[REDACTED]
CITY	TEMPLE, TX 76501
COUNTY	Bell
ZIP	[REDACTED]
TELEPHONE	[REDACTED]
MOBILE	[REDACTED]
EMAIL	[REDACTED]

Inquiry Information

NPI/APL	1619203361
Eligibility From	4/1/2012
Eligibility Through	4/30/2012
Medicaid Agency No.	[REDACTED]
Special Services Number	[REDACTED]
Date of Birth	[REDACTED]
Last Name	[REDACTED]
First Name	[REDACTED]

30

Eligibility Segments

EFF	TRM	ADD	Program	Program	Benefit Plan	System Code
3/1/2012	6/30/2012	3/30/2012	48 RIBICOFF CHILDREN UNDER AGE 4 WITH INC	REGULAR	R	100 - TRADITIONAL MEDICAID

Medicare Segments

No Medicare Segments found

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

Managed Care Segments

No Managed Care Segments found

Limits Segments

Limit	From	To	Class	Code
				9/22/2009

100020030201218147766903 / paid

The JS 44 civil coversheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

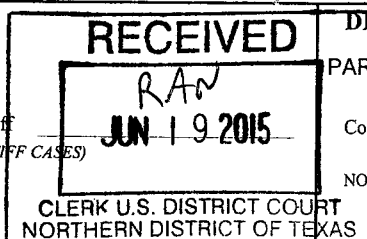
I. (a) PLAINTIFFS

PARTIES UNDER SEAL

(b) County of Residence of First Listed Plaintiff
 (EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys (Firm Name, Address, and Telephone Number)

WITT, MCGREGOR & BOURLAND, P.L.L.C., 8004 Woodway Dr., #400,
 Waco, TX 76712



DEFENDANTS

PARTIES UNDER SEAL

County of Residence of First Listed Defendant **ELLIS**
 (IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☒ 1 U.S. Government Plaintiff
☐ 2 U.S. Government Defendant
☐ 3 Federal Question (U.S. Government Not a Party)
☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

- | | | | | | |
|-----------------------------------------|----------------------------|----------------------------|---------------------------------------------------------------|----------------------------|----------------------------|
| | PTF | DEF | | PTF | DEF |
| Citizen of This State | <input type="checkbox"/> 1 | <input type="checkbox"/> 1 | Incorporated or Principal Place of Business In This State | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
| Citizen of Another State | <input type="checkbox"/> 2 | <input type="checkbox"/> 2 | Incorporated and Principal Place of Business In Another State | <input type="checkbox"/> 5 | <input type="checkbox"/> 5 |
| Citizen or Subject of a Foreign Country | <input type="checkbox"/> 3 | <input type="checkbox"/> 3 | Foreign Nation | <input type="checkbox"/> 6 | <input type="checkbox"/> 6 |

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT <input type="checkbox"/> 110 Insurance <input type="checkbox"/> 120 Marine <input type="checkbox"/> 130 Miller Act <input type="checkbox"/> 140 Negotiable Instrument <input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment <input type="checkbox"/> 151 Medicare Act <input type="checkbox"/> 152 Recovery of Defaulted Student Loans (Excl. Veterans) <input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits <input type="checkbox"/> 160 Stockholders' Suits <input type="checkbox"/> 190 Other Contract <input type="checkbox"/> 195 Contract Product Liability <input type="checkbox"/> 196 Franchise	TORTS PERSONAL INJURY <input type="checkbox"/> 310 Airplane <input type="checkbox"/> 315 Airplane Product Liability <input type="checkbox"/> 320 Assault, Libel & Slander <input type="checkbox"/> 330 Federal Employers' Liability <input type="checkbox"/> 340 Marine <input type="checkbox"/> 345 Marine Product Liability <input type="checkbox"/> 350 Motor Vehicle <input type="checkbox"/> 355 Motor Vehicle Product Liability <input type="checkbox"/> 360 Other Personal Injury <input type="checkbox"/> 362 Personal Injury - Med. Malpractice PERSONAL INJURY <input type="checkbox"/> 365 Personal Injury - Product Liability <input type="checkbox"/> 367 Health Care/Pharmaceutical Personal Injury Product Liability <input type="checkbox"/> 368 Asbestos Personal Injury Product Liability PERSONAL PROPERTY <input type="checkbox"/> 370 Other Fraud <input type="checkbox"/> 371 Truth in Lending <input type="checkbox"/> 380 Other Personal Property Damage <input type="checkbox"/> 385 Property Damage Product Liability	FORFEITURE/PENALTY <input type="checkbox"/> 625 Drug Related Seizure of Property 21 USC 881 <input type="checkbox"/> 690 Other LABOR <input type="checkbox"/> 710 Fair Labor Standards Act <input type="checkbox"/> 720 Labor/Mgmt. Relations <input type="checkbox"/> 740 Railway Labor Act <input type="checkbox"/> 751 Family and Medical Leave Act <input type="checkbox"/> 790 Other Labor Litigation <input type="checkbox"/> 791 Empl. Ret. Inc. Security Act IMMIGRATION <input type="checkbox"/> 462 Naturalization Application <input type="checkbox"/> 463 Habeas Corpus - Alien Detainee (Prisoner Petition) <input type="checkbox"/> 465 Other Immigration Actions	BANKRUPTCY <input type="checkbox"/> 422 Appeal 28 USC 158 <input type="checkbox"/> 423 Withdrawal 28 USC 157 PROPERTY RIGHTS <input type="checkbox"/> 820 Copyrights <input type="checkbox"/> 830 Patent <input type="checkbox"/> 840 Trademark SOCIAL SECURITY <input type="checkbox"/> 861 HIA (1395ff) <input type="checkbox"/> 862 Black Lung (923) <input type="checkbox"/> 863 DIWC/DIWW (405(g)) <input type="checkbox"/> 864 SSID Title XVI <input type="checkbox"/> 865 RSI (405(g)) FEDERAL TAX SUITS <input type="checkbox"/> 870 Taxes (U.S. Plaintiff or Defendant) <input type="checkbox"/> 871 IRS—Third Party 26 USC 7609	OTHER STATUTES <input checked="" type="checkbox"/> 375 False Claims Act <input type="checkbox"/> 400 State Reapportionment <input type="checkbox"/> 410 Antitrust <input type="checkbox"/> 430 Banks and Banking <input type="checkbox"/> 450 Commerce <input type="checkbox"/> 460 Deportation <input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations <input type="checkbox"/> 480 Consumer Credit <input type="checkbox"/> 490 Cable/Sat TV <input type="checkbox"/> 850 Securities/Commodities/Exchange <input type="checkbox"/> 890 Other Statutory Actions <input type="checkbox"/> 891 Agricultural Acts <input type="checkbox"/> 893 Environmental Matters <input type="checkbox"/> 895 Freedom of Information Act <input type="checkbox"/> 896 Arbitration <input type="checkbox"/> 899 Administrative Procedure Act/Review or Appeal of Agency Decision <input type="checkbox"/> 950 Constitutionality of State Statutes
REAL PROPERTY <input type="checkbox"/> 210 Land Condemnation <input type="checkbox"/> 220 Foreclosure <input type="checkbox"/> 230 Rent Lease & Ejectment <input type="checkbox"/> 240 Torts to Land <input type="checkbox"/> 245 Tort Product Liability <input type="checkbox"/> 290 All Other Real Property	CIVIL RIGHTS <input type="checkbox"/> 440 Other Civil Rights <input type="checkbox"/> 441 Voting <input type="checkbox"/> 442 Employment <input type="checkbox"/> 443 Housing/Accommodations <input type="checkbox"/> 445 Amer. w/Disabilities - Employment <input type="checkbox"/> 446 Amer. w/Disabilities - Other <input type="checkbox"/> 448 Education	PRISONER PETITIONS <input type="checkbox"/> 510 Motions to Vacate Sentence Habeas Corpus: <input type="checkbox"/> 530 General <input type="checkbox"/> 535 Death Penalty <input type="checkbox"/> 540 Mandamus & Other <input type="checkbox"/> 550 Civil Rights <input type="checkbox"/> 555 Prison Condition <input type="checkbox"/> 560 Civil Detainee - Conditions of Confinement		

V. ORIGIN

- (Place an "X" in One Box Only)
☒ 1 Original Proceeding
☐ 2 Removed from State Court
☐ 3 Remanded from Appellate Court
☐ 4 Reinstated or Reopened
☐ 5 Transferred from another district (specify)
☐ 6 Multidistrict Litigation

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
 31 U.S. Code Section 3730(b)

Brief description of cause:

An original source of information brings suit against a medical provider under the False Claims Act.

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23

DEMAND \$

3 Million Dollars

CHECK YES only if demanded in complaint:

JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) PENDING OR CLOSED:

(See instructions):

JUDGE Jane J. Boyle

DOCKET NUMBER 3:15-CR-66-B(01)

DATE

06/16/2015

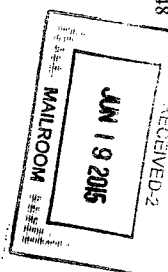
SIGNATURE OF ATTORNEY OF RECORD

[Handwritten Signature]

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

Matthew C. Witt
Witt, McGregor & Bourland, P.L.L.C.
8004 Woodway Drive, Suite #400
Waco, TX 76712-3648



U.S. District Clerk
1100 Commerce Street, Room 1452
Dallas, TX 75242

